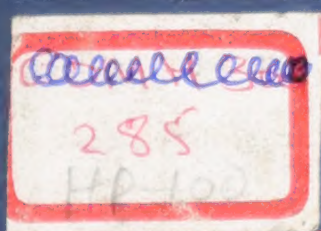


VHAI



Seminar On The National Health Policy — a report

New Delhi, April 23, 1983



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WHY THIS SEMINAR ?

When the Voluntary Health Association of India first printed the Government's Statement on the National Health Policy, we were swamped with requests from individuals and institutions from all over the country for copies. In some cases bulk supplies were requested.

This widespread interest inspired VHAI to plan a systematic dissemination and discussion of the policy document. Two New Delhi-based organizations were approached to collaborate in holding a national seminar, followed by state-level seminars, to be sponsored by the Voluntary Health Associations, where possible.

It was felt that, besides several organizations and institutions, Members of Parliament attached to the Parliamentary Consultative Committees of the Ministries of Health and Family Welfare, Education and Social Welfare, Rural Development, Fertilizers and Chemicals should also participate in the seminar.

April 7 was observed as the World Health Day.

April 23, a fortnight before the summer session of Parliament was to end, seemed an appropriate date for holding a one-day seminar to discuss the national health policy of the Government.

The three collaborating organizations had a month to contact a selected number of institutions and organizations for this purpose.

A preliminary selection of issues for discussion were:

Population Stabilization, Medical and Health Education, Low Cost Drugs and Rational Therapeutics, Nutrition and Environmental Factors, Management of Health Information Systems, Funding of the Voluntary Sector for Health Education, Effective Drug Control and Distribution Mechanism, and Monitoring, Review and Progress of the Health Care Programmes.

There were, of course, differing views as to what may be laid down as the objective of this one-day seminar.

One view was that, by confining this seminar to voluntary development and health-oriented organizations, one could hope to draw up a critique of the health policy with the help of those who have field experience.

Another opinion was that a day's seminar would only help to disseminate the salient features of the document to some persons.

A third view was that newspaper publicity of the Statement would perhaps be the sole achievement.

The Health Policy is an exhaustive document. There is obvious need for a wide and intensive study of it to enable people and organizations to make a conscious effort to convert plans into action. Therefore, dissemination of the policy and identification of modalities for collaboration with the Government in its implementation at every level was set as the main objective.

As there was some risk of the discussions going off at a tangent, and some of the topics becoming too diffused, it was decided to form a Steering Committee of experienced and professional individuals with a commitment to their respective areas of work.

Since many of them are holding responsible positions in the Government, the organizers benefited greatly from the three sessions of the Steering Committee held on April 11, 12 and 13, 1983, which provided a colossal amount of information and statistics on the health care situation in the country today. The educational value of these meetings for the organizers of the seminar was great. Further, they drew out the critical areas where collaboration between the Government and voluntary agencies was indispensable.

Following the Steering Committee meetings, there was a consensus about the need to reduce the number of subjects to be discussed from seven to five and to change the priorities of discussions. Those finalized for discussion were:

- A. Health Care Education and Training
- B. Nutrition
- C. Environment
- D. Low Cost Drugs and Rational Therapeutics
- E. Population Stabilization

The Steering Committee members expressed their apprehension about the limited time being one of the constraints for discussions of the issues in depth.

They agreed that questionnaires seeking basic and critical data from the participants' respective areas of involvement could provide them the required stimulus for meaningful discussions.

Some members agreed to assist in the formulation of these questionnaires.

These were drawn up and mailed to all the selected participants.

A copy of the health policy had been sent to them earlier with a note from Prof. D. Bannerji. Some photo-copies of a paper by Dr. K.S. Sanjivi, analysing the policy, were also taken and shared with a few participants.

Invitation letters were sent to the Members of Parliament attached to the Consultative Committees of the four Ministries mentioned earlier.

The Delhi Municipal Corporation and the Metropolitan Council of the Union Territory of Delhi were informed about the seminar.

Heads of educational, social and cultural organizations in New Delhi were also invited to attend the inaugural and closing functions. They were also given the facility to participate in the discussion groups.

Convener of the Seminar

FOR INFORMATION

Following the national seminar, State level seminars on the National Health Policy are being planned in Kerala, Andhra Pradesh and Bihar. The West Bengal Voluntary Health Association will hold a seminar in collaboration with the Child in Need Institute, 24 Parganas and the All India Institute of Hygiene and Public Health in Calcutta on September 16, 1983.

PROFILES OF THE ORGANISERS

The Voluntary Health Association of India

The Voluntary Health Association of India, a dream of some individuals who believed strongly in social justice in health care, was given form in 1970.

It is a federation of state voluntary health associations (VHAs) comprising institutions and organisations which are non-Governmental and non-profit making.

Among the many achievements to its credit is the nurses' anaesthesia course now recognised by the Indian Nursing Council.

VHAI has also been involved in revamping the ANM curriculum to make it more socially relevant.

Many voluntary health institutions often face financial difficulties due to management problems, rising drug prices, increase in demand for qualified health personnel who demand higher salaries etc. The need to give attention to this aspect of the health care administration was recognized very early by the VHAI. Therefore, it organized a Health Care Administration Education programme and courses geared to the needs of small hospitals, dispensaries and health centres.

The VHAI today also conducts short clinical training programmes for medical auxiliaries, e.g. Public Health Nurses, ANMs etc., who are independently in charge of small health centres and dispensaries to fulfil the need for trained health care personnel in the tribal areas of Bihar and Madhya Pradesh.

The VHAI is also encouraging the use by the people and the health care personnel, of certain simple home remedies and non-drug therapies and simple compounding of some common mixtures and ointments.

The organization also strengthens programmes to create awareness about the health situation in the country among:

- (a) The people and institutions who have not yet had contact with changing approaches to health care.
- (b) The people at various levels, already in health and development programmes, helping them to make health a reality for all.
- (c) The young professionals in all disciplines, informing them about the philosophy, activities and opportunities the VHAI offers.

It proposes to initiate an ongoing Plan of Action to coordinate the activities of agencies and action groups, whenever possible, through:

- (a) Sharing information on HEALTH NEEDS.
- (b) Promoting SOCIAL JUSTICE in the provision and distribution of health care, and development.
- (c) Assisting in appropriate LEGISLATION.

It hopes to continue the development, expansion and implementation of INNOVATIVE EDUCATIONAL programmes to meet the changing needs of all levels of personnel involved in health care and related fields including:

- (a) Continuous evaluation, revision and follow-up.
- (b) Development of appropriate, low-cost and relevant teaching-learning materials and improved communication methods, using simple style and local languages.

The VHAI also wants to link with the resource people and organization in planning, implementing and evaluating programmes in health care and related developments and insuring COMMUNITY INVOLVEMENT and PARTICIPATION at all stages.

All India Women's Conference

The AIWC dates back to 1926, when Mrs Margaret E. Cousins, a social worker and philanthropist, appealed to the women of India to join hands to air their problems in the fields of education, women's franchise and then suggested formation of local committees for this purpose.

As early as in 1917, a deputation of Indian women, led by Mrs Sarojini Naidu, met Lord Chelmsford, the then Viceroy of India and also Secretary of State, and demanded that "Women may be recognised as people" when the franchise was being drawn up. This was followed by an active campaign for women's suffrage by Mrs H. Tata and Miss M. Tata in 1919 in London where the campaign received strong support from British women. Both these women from India were well known social workers, deeply interested in women's welfare.

By 1918, various women's organisations and social welfare organizations came into existence, promoting the cause of women and thus linking together women all over India. The major step in this linking process was the formation of the AIWC which brought women together on a common platform.

The first AIWC conference was organised in Poona in January 1927 and representatives of 20 branches all over India participated in it. Today there are as many as 102 branches and AIWC has a total membership of over a hundred thousand women from all walks of life. Besides the local branches there are international branches of the AIWC in cities like London, Moscow and New York.

Its aims and objects are:

- (a) To work for a society based on the principles of social justice, personal integrity and equal rights and opportunities for all.

- (b) To secure recognition of the inherent right of every human being to work, and to the essentials of life such as food, clothing, housing, education, social amenities and security in the belief that these should not be determined by accident of birth or sex but by planned social distribution.
- (c) To support the claim of every citizen to the right to enjoy basic civil liberties.
- (d) To stand against all separatist tendencies and to promote greater national integration and unity.
- (e) To work actively for general progress and welfare of women and children and to help women benefit, to the fullest, from the Fundamental Rights conferred on them by the Constitution of the Indian Union.
- (f) To cooperate with people and various organisations of the world for the implementation of these principles which alone can assure permanent international peace.

Among the AIWC's activities are organising conferences relating to women's problems, social welfare programmes and services.

Concern for Correct Medicine

This is an organisation devoted to research in health matters. Its main interest is to find correct and least harmful medicines for various diseases. Hence the name Concern For Correct Medicine.

The society has its genesis in the professional work of its promoters which, though not directly related to medical work of any kind, gave them an opportunity to plan, write and publish books on diseases and their cure through the various systems of medicine prevalent today. Some of these books have already been published while others are in the various stages of preparation. They include books on Nature Cure, Yoga, Herbs and Home Remedies, Homoeopathy, Ayurveda, Unani, Siddha, Magnetotherapy etc. Another important work by a team of pharmacologists is a compendium of modern allopathic drugs describing their adverse effects.

This work gave rise to the idea that at a time when modern drugs are losing their hold on their users in the West and are being condemned all over the world, India may develop a line of thinking and investigation geared to evolving an alternative system whether they be Unani, Homoeopathic or Ayurvedic, or even allopathic which would find out the easier and better and also if possible cheaper cures for various diseases.

The CCM was created to aim at a style of functioning which is unbiased in respect of the various systems of medicine. It plans to collaborate with experts in the various systems without being unduly influenced by them.

The CCM feels certain that correct food and living habits can minimise the need for medicine and that, in cases of diseases, the first resort should be nature cure and home remedies.

It also feels that much useful work has already been done in these areas though it has not been disseminated among the masses for their benefit. The CCM is trying to do just this.

Among its many programmes are:

Investigating alternative systems of medicine throughout the world and assembling a library of works on these systems.

Preparing simple and introductory works on them and to initiate comparative studies.

Keeping track of new developments in the various systems and new knowledge being added to them.

Establishing machinery to check the claims of the various systems regarding the cures.

Initiating steps to compare cures of the various systems in order to find easier and better cures.

Investigating the benefits of Nature Cure, Home Remedies and Yoga and also their limitations in effecting cures.

Disseminating knowledge about the harmful effects of modern drugs.

Investigating and clearly underlining the areas where modern medicine is the only alternative.

Investigating intractable cases with the help of a panel of experts in the various systems.

Starting popular journals in English and Hindi to educate and guide the masses in matters of health.

Preparing correct food and living guides and guides on common diseases that can be cured by naturopathy and home remedies.

Arranging easy supply of home remedies that are presently not easily obtainable.

THE STEERING COMMITTEE

The Steering Committee met on April 11, 12 and 13 from 6 to 8 p.m. at the India International Centre.

Members of the committee were:

Dr S.V. Apte,
Dy. Director General,
Indian Council of Medical Research,
Ansari Nagar,
New Delhi - 110029.

J.S. Bali, Former Additional Secretary,
Ministry of Health and Family Welfare,
C-66, Defence Colony,
New Delhi - 110024.

Prof D. Banerji,
Director,
Centre for Social & Community Medicine,
Jawaharlal Nehru University,
New Delhi - 110067.

Dr Indra Bhargava,
Dy. Director (MCH),
Ministry of Health and Family Welfare,
Nirman Bhawan,
New Delhi - 110001.

Brig S.L. Chaddha, Consultant
National Institute of Communicable Diseases,
Alipur Road,
Delhi - 110008.

Smt Priya Desh,
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Dr V. Dutta Mullick, Hony. Secretary,
Family Planning Association of India,
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New Delhi - 110022.

Mr J.M.T. Fransen,
(UNFPA) U.N. Development Programme,
55 Lodi Estate,
New Delhi - 110003.

Dr P.N. Ghei,
Secretary - General,
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New Delhi - 110001.

Shri Vinay Malik,
Drugs Commissioner,
Ministry of Fertilizers & Chemicals,
Shastri Bhavan,
New Delhi - 110001.

Dr (Smt) S. Malhan,
Director,
Institute of Home Economics,
South Extension Part I,
New Delhi-110049.

Smt Kamla Mankekar,
Convenor (U.N. Affairs),
All India Women's Conference,
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New Delhi - 110016.

Dr Tunnie Martin,
Voluntary Health Association of India,
C-14, Community Centre,
Safdarjang Development Area,
New Delhi - 110016.

Shri S.S. Nair,
Director (Evaluation),
Ministry of Health & Family Welfare,
Nirman Bhawan,
New Delhi - 110001.

Dr M.M. Nath,
ENT Surgeon,
S-273 Panchshila Park,
New Delhi - 110017.

Dr V.N. Pandey,
Director, Central Council for Research
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Dharam Bhavan,
S-10, Green Park Extension,
New Delhi - 110016.

Dr (Miss) Bina Roy,
Social Scientist and Editor,
C-28, Sujan Singh Park,
New Delhi - 110003.

Dr (Smt) S.K. Sandhu,
Director, Health Services, Delhi State,
Saraswati Bhavan, E-Block,
Connaught Circus,
New Delhi - 110001.

Dr B.N. Saxena,
Senior Dy. Director General,
Indian Council of Medical Research,
Ansari Nagar,
New Delhi - 110029.

Shri N.K. Shejwalkar,
(Advocate) Member of Parliament
from Madhya Pradesh,
6, Ferozeshah Road,
New Delhi - 110001.

Dr Mira Shiva,
Coordinator,
Low Cost Drugs and Rational Therapeutics,
Voluntary Health Association of India,
105, Rajpur Road,
Dehra Dun - 248001.

Dr Harcharan Singh,
Jt. Adviser, Planning Commission,
Health and Family Welfare,
Yojana Bhavan,
Parliament Street,
New Delhi - 110001.

Dr Y.L. Vasudeva,
Prof of Preventive Medicine,
Rohtak Medical College,
Rohtak,
Haryana.

Mr Anthony T. D'Souza,
Chairman,
Steering Committee,
Voluntary Health Association of India,
C-14, Community Centre,
Safdarjang Development Area,
New Delhi - 110016.

Smt Purabi Pandey,
Convener,
Steering Committee,
Voluntary Health Association
of India,
C-14, Community Centre,
Safdarjang Development Area,
New Delhi - 110016.

PARTICIPATING BODIES

Representatives from the following organizations participated in Seminar on the National Health Policy, held in New Delhi on April 1983:

Voluntary Health Association of Andhra Pradesh

Voluntary Health Association of Madhya Pradesh

Voluntary Health Association of Meghalaya

Voluntary Health Association of West Bengal

National Organizations and Institutions

Andhra Pradesh

HUT - Institute of Human Development, Vishakapatnam

Bihar

Federation of the Medical Representatives Association of India, Patna

Gujarat

Consumer Education and Research Centre, Ahmedabad

Vikas Centre for Development, Ahmedabad

Vikram Sarabhai Community Science Centre, Ahmedabad

Kerala

Health O'Millions Programme, Trivandrum

Maharashtra

Consumer Guidance Society of India, Bombay

National Alliance for Nutrition of Infants, Bombay

Foundation for Research in Community Health, Bombay

Rajasthan

Jan Swasthya Sikshan Forum, Jaipur

Tamilnadu

Rural Unit for Health & Social Affairs (RUHSA), North Arcot District

VHS - Chidambaram Institute of Community Health, Madras

West Bengal

Child in Need Institute (CINI), 24, Parganas

New Delhi

India International Centre, (Environment Group)

Vishwa Yuvak Kendra

Central Council for Research in Ayurveda and Siddha

National Institute for Public Co-operation and Child Development (NIPCCD)

Indian Council of Social Science Research (ICSSR)

Employees State Insurance Corporation

Institute of Social Studies Trust
 Centre for Women's Development Studies
 Council for Social Development
 Youth and Family Planning Programme Council
 Institute of Haematology
 Family Planning Association of India
 Family Planning Foundation
 Bharatiya Adimjati Sevak Sangh
 National Council for Women in India
 National Parent Teacher Association
 Young Women's Christian Association
 Bharatiya Grameen Mahila Sangh
 Indian Social Institute
 Action for Food Production (AFPRO)
 Indian Housewives' Federation
 Centre for Science and Environment

Other organizations/institutes

Institute of Home Economics
 University Women's Association of Delhi
 War Widows Association
 Guild of Service
 Bapnu Ghar - a home for women in distress, Delhi
 Delhi State Council of Women
 Consumers Action Front, Delhi

Universities

Department of Education, Delhi University
 Population Research Centre, Institute of Economic Growth,
 Delhi University
 National Service Scheme (Students), Delhi University
 S.N.D.T. Women's University, Bombay
 Jawaharlal Nehru University, New Delhi

Representatives and officials of the Statutory Public Bodies

Lok Sabha
 Rajya Sabha
 Delhi Metropolitan Council
 Delhi Municipal Corporation

Officers representing the following departments were associated with the preparatory meetings for the seminar:

The Planning Commission
 Department of Health and Family Welfare
 Development Commissioner (Drugs), Ministry of
 Fertilizers and Chemicals
 *National Institute of Communicable Diseases
 *Directorate of Health Services, Delhi Administration
 *Drug Controller's Office, Delhi Administration
 Indian Council of Medical Research (ICMR)

**also present at the seminar*

Hospitals/laboratories

Andhra Pradesh

Star of Hope Hospital, Akividu

Bihar

Duncan Hospital, Raxaul

Haryana

Rohtak Medical College

Himachal Pradesh

Tibetan Welfare Delak Hospital, Dharamsala

Uttar Pradesh

Pharmacopoeical Laboratory for Indian Medicine, Ghaziabad

New Delhi

All India Institute of Medical Sciences

Jivodaya Hospital, Ashok Vihar

International Organizations/U.N. Specialized Agencies

UNDP/UNFPA

UNICEF

DANIDA

Representatives from the organizations which sponsored the seminar

Voluntary Health Association of India

All India Women's Conference

Concern for Correct Medicine

INAUGURATION

Following is the text of the speech by the President of the Voluntary Health Association of India at the inaugural Session of the Seminar on the National Health Policy, New Delhi - April 23, 1983:

This is a unique seminar where VHAI and other voluntary organizations interested in the health and welfare of the people have got together along with the Government of India to deliberate on the National Health Policy so that health services are possible for all by the year 2000 AD.

The Government has planned the services after studying the problems of different states and included them in the Five-Year Plans. Each plan was and is still discussed every year by the Central Health Council and due changes are made in the health services structure and the pattern of implementation after careful review and discussions.

The Bhore committee, in 1943-1946, had suggested a system of primary and secondary health centres and soon after Independence a pattern emerged based on the primary health centre in each community block which was a unit of 60,000 in the '50s but is now one PHC for a population of 100,000 due to a rapid increase in population. Similarly, at first only three subcentres came into existence in a block. Later on this number was increased to one for every 10,000 people. These days some states have one subcentre for 5,000 people, manned by one male and one female worker.

The above pattern and structure have been changing with the need and experience gained by the states after implementing the services for a given period.

At the same time, the voluntary sector has also been active experimenting in health advancement and development in the field taking into consideration the needs of local communities. They have made valuable contributions through their experiments, some of which have been already used in the national network. One such experimental scheme has been that of the community health worker, one for every 1,000 people. This means providing five such workers in each subcentre.

It is all very well to have these different structures and patterns of health services. For them to succeed, we need very specific supervision. The incharge has to be efficient as a community health worker, an auxiliary nurse-midwife, and a male worker involved in other jobs too. The supervisor has to have a vision of the total need of the various communities involved, the resources available, the social structure, the local remedies and their use. He or she has also to be familiar with the various organizations working in the area and the method by which most of

them can be geared to give the maximum benefit to the communities for which they have been meant.

I think there are several lacunae in this regard, both in the Government and the private sector and together we have to face our mistakes and make use of our successes.

It is obvious that the national health programme has not succeeded completely as, even today, all our communities do not have health service facilities. This, despite the six Five-Year Plans and various other projects.

This seminar is the first attempt to review the situation and I do hope there will be many more in the future and of longer duration where seminars and conferences can be combined.

May I suggest that we ought to work out a specific method by which coordination is possible between the Government and the many voluntary organizations in the country and also among the various voluntary organizations.

VHAI is a central organization which can act as coordinator for the voluntary sector. The Government should also have OSDs at the central, state and district levels so that all voluntary efforts in this field are pooled by this department and the Government and voluntary efforts are coordinated.

Following this preamble, today's theme for discussion will be based on five important issues, as the whole national policy cannot be discussed in a one-day seminar.

Health Care Education and Training

We have to face the fact that we have failed somewhere in training our medical and para-medical cadre for the job which we expect from them for effective implementation of our National Health Policy. Are we now going in the right direction? Can the voluntary sector influence Government policies with its experience? Has the creation of the departments of social and preventive medicine fulfilled the need for which they were created? If not, why not? The same is true of such other departments.

Also let there be representation in the Central Health Council for VHAI and other important voluntary organizations. Also, members from the Medical Council, the Nursing Council and the social welfare department should find a place in the Central Health Council.

Population Stabilization

The Government has travelled a long way in the Family Planning Programme since 1952 when the first international conference on family planning was held in Bombay. Various experiments in administration and contraception have been tried in the meantime. Some of the methods have been accepted while others have been criticised by the populace.

In this field, the voluntary section has to join hands with the Government and give feasible and honest advice to ensure stability of the population.

Here again are we covering the fertile population in the real sense and are we fulfilling the targets? Is the cafeteria method really used? Is it feasible?

Nutrition.

A lot of research has been done on nutrition by the ICMR and other national and international agencies. Now one has to consider whether all the results of the research are translated into action; this is what matters. We can keep on producing pills, feeds and supplements but, unless they reach the sections they are intended to benefit, they are all of no use.

Different states and different communities have different needs. Therefore food habits have to be studied and something permanent has to be evolved. While feeding programmes are of value in rural areas, they may be a waste of effort in areas of plenty. Health education and practical application are all that is needed in certain areas.

Environment Factors

This subject has been included in our discussion as we are observing the Decade for Providing Potable Water to All. In this case we need to know what the specific plans of the Government for each area are. Whom can the voluntary organizations approach for help in this field?

To be taken into account is also the extent of environment coverage possible and how. What have the voluntary bodies done in their small areas, to solve this problem?

We in Punjab tried to have bore-hole latrines and recently also a water carriage system in two or three houses in each village and we found that more and more people wanted these facilities.

Pesticides and deaths

Punjab uses a lot of pesticides and there have been cases of death from pesticides. Who should be responsible for the safety of labour—the health department, the labour department, the consumer or the firm supplying the pesticide? Instructions given in English are sometimes not understood even by rich farmers. It is no use criticising them, we should give them suggestions based on experience.

Low Cost Drugs and their use

Forty to sixty million people suffer from endemic goitre though its prevention is so cheap. Why is iodised salt not available where it is

indispensable to protect the victims from irreversible damage?

Vitamin A deficiency leads to blindness. Yet we spend more time in producing expensive drugs rather than this vitamin. There is also a lack of health education and the necessary machinery to help control blindness.

Then there are plans to control TB, malaria and leprosy.

Take the case of TB, which is eating away the tissues of two per cent of our people. Trained and untrained practitioners in the villages and cities are treating TB patients for three months or six months with streptomycin injections when a combination of two to three drugs is advised for two years. First line drugs are cheap, and, if suitably combined and given for the right time, cure the diseases. But if doctors, quacks, RMP's are producing a whole lot of drug-resistant patients, then I am afraid there is no hope of controlling TB or leprosy.

The Vaccinations Act was passed 100 years ago and vaccine has been available. Yet it has taken 100 years to control TB. The same is the story with malaria. Drugs and DDT are not available when they are needed.

Second-line drugs are pushed by companies beyond the reach of the poor.

Then certain drugs are banned by expert committees but are still being produced and marketed.

With the above remarks and with the help of the background outlined to you for each theme, we request you to group yourselves into the five panels--which will be explained by the Convener of the Seminar--and give us your valuable suggestions.

Dr Harbans Dhillon

*Proceedings of Group A
on Health Education and Training*

Discussions took place among 28 participants led by a chairperson. Two rapporteurs recorded the minutes.

The chairperson led the discussions around the areas identified in advance. Since certain points overlapped, some of them were clubbed to focus on the main issues.

The chairperson opened the session questioning how many doctors knew of the significance of primary health care and stating that such teams ought to be led by doctors.

Participants felt that old-fashioned methods of training of cadres still continued and no stress has been laid in the last 25 years on doctors' training.

They thought field training will be more practical and oriented to problem-solving. This would enable the team leader to know how to train and what the content of the training should be to be functionally useful.

They also opined that all cadres of health workers ought to be trained under the same roof and the training institutions should operate at the village level so that the training reflects the national health policy correctly.

The chairperson said there would be practical difficulties, especially financial, in trying to do so at the national level. Moreover, he felt, there would be no point in basing the medical colleges in the villages.

He also thought village health guides should be only women.

Participants, disagreeing, wanted equal numbers of male and female workers. Some suggested the selection of two workers, male or female, for two adjacent villages with overlapping populations. It was, however, felt that this might give rise to a conflict of respective roles with the selected guides mistaking their selection as job opportunities.

Some participants reported that it was becoming more and more difficult to get women health workers in Bihar and U.P. for village communities. Yet, it was felt, women can cut through the political barriers for selection since village politics is invariably involved in selection of men for such jobs.

Since the Community Health Volunteer scheme is to democratize the health situation and not meant to be a bureaucratic set up, most agreed, selections of CHVs should be left to the villagers for whom the health care system is to be built up. But, before this, the villagers must be provided all the relevant information

regarding the scheme and also asked what their requirements are and what should be provided at their village level. This, done before soliciting their participation, would ensure better cooperation.

In this context, waste of public funds for massive training facilities in the cities was regretted as such training and services plans are not suited to the people's needs.

Consensus was reached on providing a male and a female worker for every 1,000 people, with the formula to be flexible according to geographic variables.

Changes in medical manpower training were discussed next. Planners were faulted for the inadequacy of training after 35 years since the programme began. It was felt that medical cadres ought to be trained in a reoriented atmosphere. If socio-political and economic conditions today determine the state of health, medical trainees should be exposed to these factors which will equip them to handle cases arising out of these conditions, the participants opined.

To do this, plans based on the rural reality were necessary, they felt. Also training in basic sciences like sanitation is necessary. The handicapped were also often neglected. Neither did primary health care get its due importance.

The participants felt that more training in cardiac by-pass operations does not solve the above problems.

Searching for the "root cause of our sick society", the participants wanted to know how to make it healthier.

A political will to tackle the situation would cure 90 per cent of the diseases, one of them felt, and here again there was a consensus on need for a "political will to cure a sick society". A need was felt for a new curriculum for training of CHVs, to be drawn up by social scientists and social workers and not by professors of medical colleges. This curriculum ought to include some aspects of moral and ethical values. Study of the causes of poverty should also be included in it.

Voluntary organisations can best take up this job, it was felt.

One participant said that the people should be taken into confidence, "since we have realised that we are the end products of a sick training system". For better training, the old and sick system has to be changed by political will.

To meet this goal, the health priorities at the national level have to be identified first. Health care training should also include in it disaster and national calamities management.

Doctors also thought advance medical technology disillusioning and noted that there was scope for re-educating themselves.

Statistics of health care workers does not reflect the people's needs or satisfaction with the service. Therefore, it was felt, evaluation could be best made by involving the people of a health care system in the process, as they, as beneficiaries, could judge best.

Health is linked closely to ecology; so training of cadres must include this factor too. The participants also advocated recording of the existing home remedies still in practice, before they died out. These should be tested and recommended, some felt.

Thus, they felt, an effort should also be made to recognise the indigenous medical practitioners (since, often, there are no alternatives available to people) after taking into account their methods of training and practice, evaluation criteria, course content and experience.

It was concluded that ongoing education must reflect the changed social outlook from time to time.

Conclusions of Group A on Health Education and Training

Right at the beginning the question of training of doctors was taken up and a few participants shared their concern about the present approach to health care.

The group felt that doctors must be trained to lead health teams to suit local needs.

Most of the questions posed to the participants in questionnaires circulated earlier were discussed in detail.

1. The consensus was that there should be both a male and a female worker for an area inhabited by at least 1,000 people. But due to the heterogeneity of our community groupings, the population served may be kept flexible. This should also be done at the village level.
2. While discussing the selection criteria, all categories of health personnel and types of medical education were discussed. The consensus was that the selection of functionaries should be left to the community as far as possible.
3. The next three questions pertaining to training of health personnel were discussed together.

The participants actively debated the quality and the quantum of training necessary to turn out a socially conscious health functionary.

The group identified the social structure, as it exists now, as working within a sick system. It is necessary, therefore, to include socio-economic and political elements in the curriculum while planning any health care training programmes.

The group felt that need-based training programme must be devised. It also felt that all the social science discipline should have a strong village orientation which then could be included in the curriculum, keeping in view our rich heritage of tradition and culture.

All programmes, when drawn up, should include criteria for evaluation set by the people.

The group came out strongly against the collection and submission of conventional, time-consuming reports. Any health programme to be effective should reflect the quality of life of the community.

Taking into consideration the different systems of medical training that are available, the group was of the consensus

that all these disciplines should come to the rescue of the ailing health care delivery system.

An effort should also be made to recognise the indigenous medical practitioners.

Regarding the accountability of health personnel it was decided that one should be accountable to one's own conscience and the people one serves.

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*Proceedings of Group B
on Nutrition*

Discussions took place among 21 participants, led by a chairperson. One rapporteur recorded the minutes.

The group discussed nutrition as a health and economic problem.

Primarily it is a problem arising out of the poor purchasing power of the population. If the purchasing power of the people improves it would lead to improved nutritional status, it was felt.

However, it was argued that merely increasing the purchasing power need not necessarily lead to improved nutritional status of the people. An example from Gujarat was mentioned, where, in Kaira district, the purchasing power of the population was increased — as the milk cooperatives gave a good price for a litre of milk — yet the incidence of deficiency in Vitamin A (available in milk) was very high among the pre-school children in the surrounding area..

Education regarding nutrition and health is by far the most important component of any successful nutrition programme, even though increasing purchasing power is very important. Especially among rural women, as this ensures improvement in the family diet of the nutritionally vulnerable groups (children below six years).

Importance of education was emphasized by the example of the Rural Unit for Health and Social Affairs (RUHSA) project which gives one month's intensified training for some income-generating activity, along with which Nutrition and Health Education (NHE) is also given.

Setting up women's cooperatives in the processing and packaging of nutritious foods is another aspect by which nutrition of the community can be improved.

There was a query whether there was any survey to justify the statement that the processing industry actually led to improved nutritional status.

Controversy on Feeding Programmes

Some participants felt that feeding programmes should be discontinued as they make people dependent for their basic needs, which is very harmful in the long run, and as the programmes do not reach the intended beneficiaries.

Some others felt that these programmes should not be stopped as —

- (a) It will have social and political implications (many functionaries will be rendered jobless).

- (b) It will be unfair to those children in remote tribal areas where this is the only food available to them.

Therefore, the better strategy would be to insist on their qualitative improvement i.e. better and more careful selection of recipients based on nutritional and economic criteria and further to ensure that the food provided is properly utilised by effective supervision, coordination, education and integration of available health services.

The INHAP* experience in Gujarat was quoted. The RUHSA project experience was similar where it is felt that education of the women benefiting from such programmes had a long-term beneficial effect on the community's nutritional status.

It was suggested that it would be advisable to go through the health policy document and raise questions based on that statement, after which the other points could be discussed.

Nutrition content, Quality and Quantity of Primary Health Care Services:

It was suggested that the foods should be locally procured so that they are more acceptable to the recipients and more effective.

However, prior to providing the foods, dietary surveys should be done in the areas so that they meet the needs and tastes of the benefiting community.

For this, specialized persons should be appointed at the block level to control the quality of supplementary food.

As the amount of nutritious foods provided is also important, it is based on a list of recipes suggested by a central committee of nutritional experts.

Till the survey and standardization of local recipes are possible it was suggested to modify the available food supplements provided by voluntary agencies to suit local recipes by consulting available nutrition experts in the area, because it is not possible to procure food and distribute it in the given amount allocated for the same, (e.g. 30 paise allotted per child has led the officiating person to purchase RTE foods like biscuits or peppermints which were much easier to procure and distribute but which defeated the primary objective of providing nutrition).

Vitamin A, deworming, iron and folic acid tablets should be provided along with the food wherever available as they increase the absorption of food and prevent deficiencies.

lacunae in the Present Nutrition Programme

Wrong selection of recipients: It should be limited to nutritionally weak children of 0-6 years and to pregnant and lactating mothers.

*Integrated Nutrition & Health Action Project

It should be accompanied by nutrition education.
 Health services should be coordinated.
 Spot feeding must be avoided.
 Ration dilution must be avoided.
 Food wastage due to poor storage or transport should be avoided.
 Local recipes should be used where the supplement is not palatable.
 Proper cooking must be ensured.
 Personnel employed must be trained properly.

Nutrition services: Can they be delivered by non-health agencies?

There was a general consensus that this should be achieved but it should be ensured that the services are integrated and not given in an isolated manner and with equal emphasis on all components, e.g. the training given in primary child care institutions, highlights pre-school education too much. Little attention is paid to health services which leads to concentration on wrong priority thus leading to non-achievement of the objectives. Sick children, for instance, will not respond to motor development by play materials, and hungry children will not learn numbers or colour concepts.

Decentralization of nutrition services should be done but only after ensuring that the local bodies are made aware of the priorities and objectives.

Simple Criterion for judging Nutritional Status

Weight for age,	}	For this, age elicited must be correct, measurements taken must be accurate and they must be recorded properly.
Height for age,		
Wt/Ht		
Mid-arm circumference		

Wherever possible local norms for heights and weights must be used for comparisons so that errors are avoided. Local norms are usually available for comparisons.

Mid-arm circumference measurement, being an age-independent and an easy measurement to take, is the most effective in field situations where the correct age of the child is difficult to determine.

Major Nutritional Problems of Vulnerable Groups

Undernutrition due to poor purchasing power.
 Protein energy malnutrition. Poor weaning practices.
 Anaemia and worms.
 Vitamin A deficiency leading to nutritional blindness.
 Other B complex vitamin deficiencies.

Diarrhoea and worms led to further deficiencies since absorption of food was affected and this further aggravated malnutrition.

Here clarification was sought on the definition of "vulnerable group".

India

It was stated that increased nutritional needs of pre-school infants, pregnant and nursing mothers were the reasons these groups were included under the head of "nutritionally vulnerable groups". Naturally these groups from low economic strata were more vulnerable to nutritional deficiencies.

Vulnerable groups are those from economically poor backgrounds, especially pre-schoolers of 0-3 years and 3-6 years and pregnant and nursing mothers.

Nutrition Programmes in Operation Supplementary Feeding Programmes

SNP	:	Special Nutrition Programme for nutritionally vulnerable groups.
MDM	:	Mid-Day Meal scheme for school-going children.
Upgraded SNP	:	Where health inputs are also provided along with the supplementary food.
ICDS	:	Integrated Child Development Scheme where three components are provided in a package of services — supplementary food, health services inclusive of immunization, non-formal education for pre-school children and women (15-44 years).
ANP	:	Applied Nutrition Programme where land is given to be utilized for growing nutritious foods, to be provided to children of the <i>Balwadi</i> . The proceeds collected by sale of crop grown on the land should be used to give supplementary food to the weak and under-nourished children of the <i>Balwadi</i> .

Major Drawbacks of the Existing Nutrition Programmes

a) Duplication of services and dilution of services:

Isolated services were given randomly and in many places there was duplication of services with the result that many deserving were left uncovered.

b) No coordination among implementing agencies:

The Social Welfare Department implements the feeding programmes but the majority of the recipients do not secure the health inputs.

It was suggested that the voluntary agencies and primary health centres for the feeding programmes areas should aid in the implementation and coordinate with each other to provide integrated services.

Services available to recipients were according to resource availability and were distributed without planning and integration.

The "Gujarat model" was more successful in achieving the integrated approach to feeding programme as all the supplementary feeding programmes were under the Health and Family Welfare Department. So it was easier to ensure that the targeted, identified feeding programme beneficiaries received the health inputs which were necessary to bring about an improvement in the nutritional status of the recipients.

The supervisory staff was also responsible to the Health and Family Welfare Department. Therefore all the medicines are also easily made available, making provision of the equipment more effective.

This model could be duplicated in other stages to achieve Integration and Coordination which are the pre-requisites of a successful development programme.

c) Untrained workers:

The nutrition programme was expanding at such a fast rate that it was difficult to "efficiently" train functionaries for the purpose. Also, the existing training at the central/state level was of a very poor quality due to non-availability of experienced field staff to train them.

It is a hard fact that merely having professional qualifications does not equip the trainer adequately to train the functionaries appropriately.

For this it is necessary to have a re-orientation and in-service training programme for the functionaries so that they acquire the necessary skills to implement the programmes effectively at the grassroots level.

Appropriate Selection of recipients

Another very important factor which plays a vital role in the success of feeding programmes is the proper selection of recipients according to certain criteria.

At present nutrition programmes are functioning as mass feeding programmes for children who can come to the feeding centres. For a qualitative improvement it is necessary that children below three years are given priority for receiving supplementary nutrition and health services in the form of a service package.

Integration of services at the grassroot level

At present, as and when resources are available they are distributed at random to the recipients without identifying the needy, with the result that limited resources do not necessarily reach the most needy.

There is a necessity to identify recipients, after which the requirements of health inputs and food supplements must be

projected so that there is no wastage and all the target recipients are covered.

Major Food Toxins

The group did not feel qualified to list all the food toxins and state how they could be avoided. They felt that this should be done by specialists in food sciences.

Socio-cultural practices

The group felt that these would vary in different areas and therefore the recipient population of each area should be educated in order to remove harmful foods by changing local taste.

Removing all the lacunae and drawbacks stated in the existing feeding programmes would lead to an improved nutritional status.

Apart from the already suggested measures, provision of safe drinking water and improved sanitation would go a long way in bringing about an overall improvement.

Conclusions of Group B on Nutrition

The group discussed several dimensions of the nutrition issue.

The group concluded that there are various nutrition programmes in the country but at present they are operating as mass feeding programmes, the effectiveness of which is not fully achieved due to certain inherent weaknesses in the programmes. These were:

- Lack of integration of functionaries and materials/supplies
- Lack of nutrition education of functionaries and the village communities.
- Low purchasing power of recipients.
- Lack of adequate monitoring and supervision.
- Poor distribution.
- Poor palatability of food.
- Improper selection of recipients.
- Lack of adequate supply and haphazard supply.
- Lack of coordination between organizations.
- Lack of adequate physical facilities.
- Untrained functionaries at PHC levels.
- Lack of information on the importance of regional foods and their nutrient contents.
- Programmes are not need-based but depend on resource availability (e.g. vitamin A).
- Primary health centres are not fully equipped.
- Primary health centre is not assisted by voluntary organizations in delivery of services.
- Training given to nutrition centre workers is not adequate
- In spite of the importance of such programme, nutrition programme functionaries are paid poorly for the work done at the field level.
- Poor coverage of target groups.
- Lack of information from voluntary agencies.
- Lack of involvement of voluntary agencies.
- Due to inadequate storage and transport facilities, there is a lot of wastage of food aid.
- Inadequate participation of local groups in feeding programme
- Food fads and fallacies must be eradicated.

Recommendations

1. In selection of the targets for the feeding programmes care should be taken to select from the following categories:
 - i) Children between 0-6 years, chosen on the basis of nutritional status;
 - ii) Pregnant and lactating mothers; and
 - iii) Economically and socially weaker sections.

2. Regarding the physical facilities:

The local community should be actively involved to improve the preparation of food, feeding places, cleaning children's hands, and in the storage of food.

3. Need to imbibe the spirit of dedication among the workers.
4. Effective supervision of all the feeding centres should be ensured.
5. The salary of the workers at the grassroots level should be enhanced at least to that of the minimum wage for labour.
6. Sufficient orientation, training, review, monitoring and in-service training should be imparted to functionaries at all levels.
7. Nutrition education should be a major integrated part of all feeding programmes.
8. Integration and coordination among the programme functionaries and other related departments is to be ensured.
9. Involvement of local voluntary bodies at every stage of programme implementation.
10. Nutrition education should be started at pre-primary level.
11. Income generation activities for women should be accompanied by relevant nutrition education.
12. Nutrition and health education should be imparted through family-life education of locally existing food resources. Stress on production of nutritious foods.
13. Development of local recipes should be encouraged .
14. Coordinate efforts of all voluntary agencies at all levels.
15. Feeding programmes should be integrated into delivery services necessary in a nutrition programme.
16. Voluntary agencies can be involved in the intensive training of village women.
17. Voluntary agencies should assist the Government agencies in the utilization and mobilization of available resources.
18. Effective time-bound evaluation programmes should be organized.
19. Adequate follow-up action and implementation of recommendations must be done.
20. Rural employment of women should be encouraged so that the earned money is pumped in for improving the family nutrition.

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*Proceedings of Group C
on Environment*

This 13 member group was led by a chairperson. One rapporteur recorded the minutes.

The group identified a number of problems needing action on the national level in respect of both rural and urban areas.

ter

Supply of safe drinking water in adequate quantities within a reasonable distance was considered a priority.

The group felt that clean and shallow wells were essential in the rural areas and small towns. Cheap handpumps with proper maintenance facilities could provide some solution to the water problem in urban slums.

The participants were of the opinion that the National Water Supply and Sanitation Programme had made tardy progress.

The group discussed the problems of the municipalities in small towns which have meagre resources — both financial and technical and felt that they should be supported by the state.

Refrigerated water trollies should be replaced by municipal arrangements for free supply of drinking water, as is being done at the railway stations.

The group also discussed the metropolitan cities which are facing newer problems, e.g., fast-growing slums, jhuggi jhonpris and high-rise buildings.

Moreover, the participants said, industrialization is leading to pollution of water sources, particularly the rivers, through industrial effluents and the groundwater is being polluted by pesticides.

The enforcement of the Prevention of Water Pollution Act is also inadequate due to administrative deficiencies. Even the pollution of water sources through sewage is not an uncommon occurrence in towns and cities.

Domestic purification of water was very limited due to the present socio-economic conditions of the masses. This fact was recognised by all the participants.

The need to provide education to the people to ensure the proper use of available water, particularly during its shortage, was also felt.

Sanitation

Rural sanitation, particularly the programme to provide latrines and dispose animal waste, e.g., composting or bio-gas production has hardly made any progress, the participants felt.

In urban areas and cities the storm-water drains are often misused for carrying sewage, they reported. Public facilities (toilets and urinals) in places of congregation are far from adequate and dry latrines still exist in many towns. Even open-land defecation is not uncommon in towns and cities. Many schools also lack basic sanitary facilities, they said.

A new problem in the cities is the renting of garages and single rooms without toilets by many unscrupulous people.

Air Pollution

The unrestricted growth of small factories and trades in inhabited areas is creating pollution problems in most towns and cities. The participants took note of the harm done by discharge of harmful smoke by factory chimneys and spread of effluents on the land surrounding these factories. Other irritants, they said, were the smoky vehicles discharging noxious gases throughout the day. They said that the transport authorities were not controlling automobile pollution despite the existence of adequate legislation for this purpose.

Pesticides

Big farmers, who are using very large quantities of pesticides, do not submit to any legislative control at present and the use of pesticides in agriculture is inadequately regulated, according to the group.

The use of prohibited pesticides and ripening agents for fruits also pose danger to the health of the people, it said.

The manufacturers of pesticides do not spend enough on education of users and fail to provide even the antidotes as well as the minimum necessary instructions for avoidance and treatment of pesticide poisoning.

Noise Pollution

The group felt that very limited efforts have been made to control noise pollution which is growing fast in India's towns and cities. Proper town planning and avoidance of the sources of noise in the residential areas are still not receiving adequate attention, it felt.

Liquor

Clandestine distillation is frequently taking a heavy toll of human life, participants pointed out. Licensed liquor shops are allowed on National Highways and even adjacent to educational institutions, they said.

ollution Education

Voluntary and Government agencies are not adequately collaborating towards the solution of the environment problems, the group felt.

People ought to be educated on the licencing laws for new industrial projects, on control of high-rise buildings and renting of garages, it said.

Conclusions of Group C on Environment

The group reviewed the environmental situation in the country and identified the problems in relation to water supply and sanitation, environment pollution and health hazards from pesticides and liquor consumption. In regard to:

Water

The group concluded that rural and urban areas, including metropolitan cities, even after 35 years, are still grossly suffering from inadequate as well as unsafe water-supply and lack of basic sanitation.

Most villages, urban slums, jhuggi-jhonpris and small towns lack supply of drinking water and adequate sanitation.

The enforcement of the Prevention of Water Pollution Act is far from satisfactory. Small municipalities and towns lack resources and expertise to implement the programme.

Sanitation

The group concluded that there was no adequate planning for environment sanitation in metropolitan cities.

Little is being done to educate the population for proper use of water and in personal hygiene.

Pesticides

The group concluded that indiscriminate use of pesticides and sometimes even their use in the preservation of food stuffs is posing a major health hazard.

Liquor

The group condemned the policy of licensing and location of liquor shops, as well as the uncontrolled growth of illicit distilleries which have been causing loss of human lives.

Discussing the provision of the National Health Policy in relation to the above environmental health problems, the group recommended the following priorities of action.

1. The voluntary organizations are complementary to the Government and they must not be expected to initiate projects depending entirely on their own resources for implementation.
2. When licensing industries in the vicinity of cities, factors like environmental pollution should have priority over revenue considerations.

3. The town-planners, while planning high-rise buildings, should pay adequate attention to the provision of drinking water, sewerage and drainage.
4. The rules prohibiting renting out of garages for residential purposes, without toilets and water supply facilities, should be rigorously enforced.
5. In view of the fact that population is increasing, there should be prospective planning for water supply and sanitation and, other environmental needs.

It is recommended that for water management one ministry should be made responsible. This should preferably be the Works and Housing Ministry in the urban areas and the Rural Development Ministry in the rural areas.

In rural areas the emphasis should be on integrated rural development schemes. Assistance from local bodies should continue to be taken.

6. Bio-gas plants and composting schemes should be encouraged in rural areas and small towns, and sewage schemes in urban areas on a priority basis.
7. Programmes for provision of latrines in villages should be implemented and the water-carriage system for latrines in towns should receive priority attention.
8. The development of cheap tubewells for lifting deep water must be undertaken on a large scale for providing safe drinking water. Hand-pumps for this purpose must be manufactured by public sector undertakings.
9. The chimneys of the factories located within the urban areas should be so improved and adjusted (even if at a cost) so that the smoke does not affect the health of the people.
10. The manufacturers of pesticides should provide instructions in local languages for antidotes and the antidotes should be made easily available near the farmers' places of work, for e.g. in the rural dispensaries and PHCs.
11. Serious attention should be paid by the Excise and Taxation Department to the location, frequency and numbers of the liquor shops coming up. These should not be allowed on highways, near schools, colleges and residential areas. Public education programmes on prohibition by the Government publicity department should be strengthened with the active support of voluntary organizations.
12. Through effective legislation, all public means of transport should be checked for smoke nuisance by the police department, particularly at the time of the annual registrations.

13. Effective legislation for control of noise pollution should be enacted and enforced.
14. The group strongly supported the proposal to establish satellite towns around metropolitan cities in order to diffuse the population and make use of natural resources like water.
15. Taking into consideration the vital role of health, the voluntary agencies should now take up health care as an important function and duty. They should be broadbased enough to provide attention, persuade and motivate the public in matters of civic sense and social obligations.

Voluntary agencies should be the link between the public and the Government for the elimination of pollution. The voluntary agencies should be given the mandate for overall monitoring, implementation and maintenance of anti-pollution services.

Services of voluntary agencies should be recognised and utilised for monitoring the environmental health measures.

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*Proceedings of Group D
on Low Cost Drugs & Rational Therapeutics*

Discussions took place among 16 participants led by a chairperson. One rapporteur recorded the minutes.

After the participants were introduced briefly, the discussions opened with the General Secretary of the Federation of Medical Representatives in India sharing with the group the reason of his leaving the Glaxo drug manufacturing company and joining full time as the General Secretary of the Federation of Medical Representatives' Association of India.

He was requested to talk about this to allay the misgivings of the other participants who were not aware of his contribution in the drugs issue, at finding the General Secretary of the Medical Representatives Association with them.

He mentioned that, in 1977, the production cost of the Betmethazone Betnelan bulk drug had come down substantially but that this decrease in cost was not extended to the consumer.

This was reported in the Blitz newspaper of July 17, 1977. Though the cost of the drug was decreased a little bit, the Government orders were not heeded and Glaxo stuck to its original price. This was exposed by the participant and because of this, on trumped up charges, he was forced to leave.

Regarding prices, the Deputy Drug Controller, Delhi, mentioned that the prices of drugs are fixed by the Ministry of Petroleum and Chemicals.

The role of the Drug Control Authorities was to ensure that the drugs are sold at the prices indicated.

Outlining the background of the control system in India, he mentioned that it was only after the Bhore Committee report in 1945, under the British, that the Government considered seriously the need for drug control and planned for it. Implementation of this was started only after Independence.

The Central Drug Controller of India dealt with the import, manufacture and sales of drugs as well as export.

No new drug could be marketed in India without prior permission from the controller. Drug control is a concurrent subject in the Indian Constitution.

The Drug Controller of Delhi covers quality control, sales and advertisements.

In the discussion, a note was made of the study in 1965 in the USA, of the drugs in the market, which had shown 60 per cent of them to be unessential and ineffective.

All the raw materials which go into manufacture of drugs are supposed to be tested and there is product quality-control of the manufactured products too.

The participants felt that the stock in the retail shops and of the chemists should also be tested.

According to the Deputy Drug Controller, Delhi, the authorities do aim at good manufacturing practices including streamlining of the counter-check system for each and every step in production to aim at zero error. Maintenance of proper records, storage and dispensing are also important aspects of drug management.

While talking about Drug Control Authorities and their active contribution, a participant from the Consumer Education & Research Centre, Ahmedabad, felt that the control authorities have a very narrow approach.

She related the Consumer Education & Research Centre's experience with one Dr Swaroop's Sex Cure Clinic. She felt that, seeing the Sablok Clinic's success, apparently Dr Swaroop is getting bolder as are his advertisements. Actually, the clinic's advertisements are illegal under Section III of the Food and Drug Control Act. Though she, on behalf of the CERC, had approached the Secretary Health, legal advisers, the Drug Controller of India and the local Police Commissioner, nothing had happened, as there was no role clarification of the controlling authorities as to who was to be actually responsible.

Dr Swaroop is not willing to allow his degrees and documents to be checked. The question that arises is: 'Why should consumer groups have to make an FIR and have to bring to the Government's notice such cases when there is already a Government Drug Control Department to ensure that no false claims are made nor blatant flouting of laws and acts are done.'

This participant gave another example of the false claims being made blatantly; this was a one-page, open advertisement in a leading newspaper for a *mantra*. This first paragraph promised solution to 'family problems', the second dealt with the issue of childlessness.

Apparently advertisement of remedies for sexual impotence and infertility are not allowed under Section II of the Magic Remedies Act. In this particular case, the *mantra* was mentioned in the beginning of the page and not specifically with the line on infertility and impotency. It was, therefore, strangely quite legal and acceptable to the authorities.

According to the participant, promises of happy married life in such an advertisement actually did mean increased sexuality and sexual pleasure and it, therefore, did amount to unethical advertising and flouting of the Magic Remedies Act.

The piecemeal approach to such advertisements by the Drug Control Authorities, as in this case, was utter nonsense, the participants felt.

Another participant pointed out a case where Dr Kabra had already sued the Sablok Clinic and the then editor Khushwant Singh for printing the advertisement in his Illustrated Weekly. Dr Kabra had specifically asked other doctors to support his move. The Deputy Drug Controller was requested to look into this seriously.

The Drug Control Authorities had lost a court case against the Sablok Clinic, since the clinic claimed their practice came under the indigenous system of medicine.

The need for control on unethical marketing of drugs as well as the unethical practice of medicine was felt *whether western or indigenous*

Another case discussed was of 'Herbofit' an ayurvedic preparation, produced by a Bombay-based company. It has 28 ingredients. The Deputy Adviser of Ayurvedic Medicine was sent samples with a request to check if "claims" tallied with the "results of the analysis". This was two years ago. Reminders were sent repeatedly without any result.

The Deputy Drug Controller felt that there were too many loopholes in the law. It is a question of "professional ethics" and, since these claim to come under the indigenous systems of medicine, the registrars of the Unani and Ayurvedic Board should look into the matter of professional ethics.

Some time ago, a case concerning a dental cream called "Ipcodental" came up. It had a heavy dose of tobacco in it. A middle-aged woman was using a single tube of this cream for two and a half days and she was affected adversely.

Her case was taken to the Food and Drug Control Department by the CERC (Consumer Education Research Centre: Ahmedabad) and a court order against the company issued. The order was challenged in Ahmedabad but the company lost the case in the High Court. It then sought permission to take the case to the Supreme Court, which was refused.

Meanwhile the word 'dental' was dropped from the name and for two years the product continued to be marketed, known now as IPCO cream.

The Food and Drug Control Department did not pursue the case despite it being taken up in the courts. The Controller who had launched the case had left.

Another advertisement some time ago saying, 'Cancer Cure within 72 hours' was flashed in various newspapers, inserted by one Mr Radhanpur from Dhikla.

The representative of the CERC met newspaper editors and requested them not to print the advertisement.

While discussing drug production, one participant made a statement that a drug can be "well produced" but it may be "unessential" and this may send the medical bills soaring.

The National Health Policy has indicated the acceptance of the idea of the Essential Drugs List. Though 23 fixed dose combination drugs were to be weeded out, as recommended by the Sub-Committee of the Drugs Consultative Committee of the Government of India, this has still not happened.

Regarding shortages of 'essential and life-saving drugs' these shortages did exist, specially of anti-TB and anti-leprosy drugs. The General Secretary of the Medical Representatives' Association felt the problems were also with the indenting, particularly when anti-TB drugs are concerned.

Since anti-TB drugs are not available, they do not get indented. An indent is made for another drug instead to prevent lapse of the drug funds.

One participant commented that Central Government Health Services (CGHS) drugs are never available, even in Delhi, in the organised sector. What must be happening in the field she could well imagine.

Withdrawal of Drugs

The drug companies did tell the drug representatives to withdraw certain batches but no warning was given to doctors as to why a particular drug was being withdrawn. At times this is done two years after the drugs have been in the market and have been already consumed, when there is actually no possibility of withdrawing them. This is done by the drug inspector who conveys the information about the withdrawal though he is not responsible for withdrawing the batch, and is no police inspector either.

The General Secretary of the Medical Representatives Association mentioned that some of the international prestigious companies' names were included in the list of companies producing substandard drugs. This was partly because of the system of loan-licensing where products produced by a small company were marketed by a bigger company, e.g. Burroughs has floated B K Pharma and Dupont has the Rama.

In 1978 Pfizer had produced five crore rupees' worth of drugs *benami* under the loan-licensing systems. The drugs were produced by the Waterbury South India Research Institute.

The Group unanimously appreciated the desire to move towards generic drugs as stated in the National Drug Policy Statement.

It was pointed out that the effort to prove a certain drug to be substandard and spurious at present had to be made by the consumer and only on his/her person depended the seriousness with which the issue was pursued.

He also commented on the Drugs and Cosmetics Amendment Act, applicable from 1.2.1983, and felt concerned that the compulsory

punishment for producers or those producing spurious drugs had been reduced to one year only.

The Deputy Drug Controller told the group that, in case of any complaints regarding unethical marketing practices, sales of banned drugs, or spurious drugs, the group members should contact him on the phone and that he would certainly take action.

Differentiating between substandard and spurious drugs, he said that substandard drugs are those produced by a licensed manufacturer but are below standard. The quantity of the drugs should be of at least within 95-105 per cent of the standard set by the Drug Controller. According to him, the limit of substandard percentage has to be drawn, below which drugs should be treated almost as spurious drugs.

He related how drug inspectors, who were trained pharmacists, did "test purchase", to identify spurious drugs and to raid the pharmacy the same day if they found anything abnormal.

He told the group there were 5,000 drug manufacturers, 2,000 factories producing bandage and other items, and 3,000 cosmetic units.

One drug inspector was recommended for 25 chemists and 100 sales units.

The VHAI wanted to know how many drug producers and chemists, selling substandard and spurious drugs, had been caught and action taken against and whether the organization could be kept informed on an ongoing basis about this.

There have been 24 cases of spurious drugs in Delhi and the offenders' licenses have been withdrawn.

The Deputy Drug Controller said those producing spurious drugs did so without licences and were criminals and rarely caught. Spurious drugs go to a consumer through a doctor or chemists (RMPs or doctors often want cheap drugs). It is important for doctors and chemists to be concerned and vigilant and help the Drug Control Authorities.

Empty capsules at present require a licence. This, it is felt, would make production of spurious drugs requiring capsules more difficult.

Quoting the Health Minister, the General Secretary of the Medical Representatives Association said that for the past three years 17.5 per cent of samples drawn from the drugs in the market were substandard.

This, according to him, came to 600 crore rupees' of drugs in three years. However, the Deputy Drug Controller and another participant were not willing to accept this figure.

Some participants were very concerned about the dumping in the market of hazardous drugs, whose production cessation dates have been indicated by the Government.

These drugs continue to be sold unchecked for long even beyond the period when sales of these drugs is supposed to be legally banned.

They felt that it was the responsibility of the Government to inform the chemists, doctors and the public in such cases. Examples were given of Unienzyme and Lomotil for children, drugs containing Amidopyrines and Phenacetin.

The rest of the discussion was around recommended action for the doctors and the Government authorities.

Conclusions of Group D
on Low Cost Drugs & Rational Therapeutics

Needs a National Drug Policy

- (1) Recommendations for a National Drugs Policy as an essential ingredient of a National Health Policy should be widely publicised (in accordance with the National Health Policy document).
- (2) Voluntary organisations involved in the drug issue should be involved in decision-making about drug policies to ensure collaboration in implementation of these policies, too.

Essential Drugs

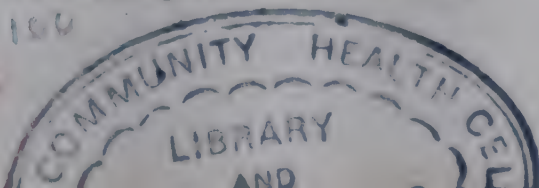
- (1) Adequate amounts of essential and life-saving drugs should be produced according to peoples' health needs and should be produced in quantities at least to fulfil the drug companies' installed capacity.
- (2) A certain fixed proportion of drugs, produced by each drug company, should constitute of essential and life saving drugs. This should be made mandatory, specially when large amounts of profitable, nonessential drugs are being produced.
- (3) Where anti-TB, anti-leprosy, anti malarial, Vitamin A drugs and fortified (iodized) salt are concerned, there should be no sales tax and excise duty. Costs should be substantially decreased for other essential and life saving drugs, too.
- (4) Quality controlled essential and life saving drugs should be available under generic names as mentioned in the National Health Policy.
(During the summing up session, a few more recommendations were made and are being included*)

* Installed capacity and drug production should be related to the population.

Information

- (1) Unbiased information and publicity of banned and hazardous drugs should be disseminated by the Government Drug Control Authorities in the national dailies, medical journals and magazines as it is their responsibility.
- (2) Drug companies withdrawing certain batches of drugs should mandatorily inform doctors, chemists and consumer about the withdrawal of these specific drugs, their batch numbers and the reasons for withdrawal.
- (3) Organisations involved in this kind of drug work should be kept informed about hazardous drugs being banned and withdrawn and about other new drugs which may be cheaper and better alternatives.

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- (4) *Information about non-drug therapies, specially locally available common home remedies, herbal medicines, etc should be made available. The Central Council for Research in Ayurveda should help towards this end.*
- (5) *Consumer caution on commonly used drugs with potential and serious side effects should be written on the package. For example, on all anti-diarrhoeals, it should be mandatorily put "Oral rehydration therapy is the main treatment for diarrhoea".*
- (6) *Voluntary organisations should play an important part in giving counter-information and a "drug information campaign" should be widely launched and well coordinated. For example, the concept of essential vs nonessential drugs, generic vs brands, hazardous drugs, combination drugs, misuse of anti-diarrhoeals, and drugs used in hormonal pregnancy tests and such matters should be brought into limelight.*

Drug Control and Drug Ban

1. *Drugs recommended for being weeded out by the Drug Consultative Committee should be withdrawn immediately.*
2. *Banned drugs should be seized and destroyed after a fixed date since such drugs are produced and dumped in the market, and continue to be sold even after the ban.*
3. *Better quality and drug control mechanism is demanded/needed. For this, the drug manufacturers and, ultimately, the Government Drug Control Authorities should be held responsible. Before being sent to the market, each batch should be quality controlled.*
4. *Detailed information should be provided to the public about the number of cases of spurious drugs detected and action taken. (A specific case of a man caught for producing and selling spurious drugs three times and released on bail was mentioned here.)*
5. *Drugs in the market should be constantly reviewed and irrational drugs phased out. An effective mechanism for this should be developed and monitoring should be an ongoing process.*

Drug Marketing

1. *Where unethical practices are concerned, e.g. in the case of the Sablok Clinic, marketing anabolic steroids, tonics, tranquillizers, even some indigenous drugs, etc, it should be the responsibility of the Drug Control Authorities to deal with the defaulters and not that of the individual citizens and consumer groups.*

2. Authentic trial reports and studies in India under Government supervision should be required before allowing a new drug in the market (this was not done in the case when sulphin pyrazone was brought to the market).

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- (1) Quality drugs should be obtained at competitive prices through open tenders. Whether it is at the district, the state or the national level, there should be greater restriction on prices of category 3 and 4 drugs instead of category 1 drugs.
- (2) Drug prices on essential drugs should be fixed on most economic packaging and not on what is put forward by the company alone. This is a matter which needs to be dealt with by the Bureau of Industrial Pricing.

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For Research and Documentation, amounts more than the present 1.1 per cent of the sales turn-over should be utilised, especially for the common tropical diseases.

sumer Action

- (1) Concerned organisations and individuals should make it a point to inform the Drug Control Authorities about the sales of spurious drugs and banned drugs or drugs without medical literature, contents and manufacturing history.
- (2) Whenever Government authorities are involved in legal proceedings against the drug industry and in efforts geared to promoting and ensuring peoples' health, doctors should support such efforts.

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*Proceedings of Group E
on Population Stabilization.*

Discussions among 21 participants were led by a chairperson. One rapporteur recorded the proceedings.

The VHAI raised some very pertinent issues on the role of family planning in bringing about population stabilization.

According to a VHAI representative, there was a difference between population control and birth control. Population control reflected the power of the state while birth control gave power to the individuals to control their fertility.

She pointed out that expenditure on family planning, as a proportion of the total expenditure on health, had been increasing. In family planning programmes, the main fact overlooked was that the population problem is a symptom and not a cause of poverty.

In the adoption of these programmes male members of the family determine the family size. There is also the prevalence of what is known as the survival hypothesis; that is, people enlarge their families in order to have children who can survive as economic assets to them. Therefore, the small family norm is not practised by the poor and the tribes.

She also pointed out that family planning programmes are target oriented and are under the complete control of the state and the medical profession. The result is that the choice of the contraceptive is never the individual's prerogative.

A very serious problem in the spread of new contraceptives is that many of these are not adequately tested at the clinical level or at the hospital level. Participants felt that most often the technical aspects of the contraceptives launched, what they exactly do or are meant for - are not explained to the people. The people, who are the actual consumers, are not taken into confidence even by the drug companies.

Agreeing with the view on the predominant role of the male in the determination of family sizes, a participant reported her experience in the state of Jammu & Kashmir, where she found that male members of the families, specially in the rural areas and among the educated population, do not believe in practising family planning methods due to the psychological preconception that such methods result in the loss of their virility or manhood.

On the other hand, women are not obsessed by such ideas. They are prepared to undergo an operation or are willing to adopt family planning methods as long as these help them in limiting their families.

ize. But, women are not allowed any say in this matter by their men.

One participant was of the opinion that family planning should form an integral part of women's development programmes. She called for a synergetic approach to family planning. For doing this she said, one should shed any ideological bias. The trouble at the moment is that one often confuses between *felt needs* and *perceived needs* of family planning.

She also said she had enough empirical support for her view that women are completely for family planning programmes, including Muslim women. What is needed is constant vigilance on the part of the administration of the family planning camps and their sound maintenance.

While weighing the risk of the contraceptives against the risk of pregnancy, it is preferable to undertake the former risk.

On the whole, it was felt, it is population control which should receive more emphasis because it goes a long way in improving the population's health status also.

One participant emphasised the need for educating men as much as women on the need for and methods of family planning.

Also essential in this regard was the provision of mobile vans for looking after pregnant women, particularly in rural areas and slums as they are unable to visit city clinics.

She also emphasized the need for ensuring economic security for children as a measure and as an incentive for limiting family size.

Another participant felt that, from the point of view of children's health, the Government should implement with all force the law banning child labour.

Yet another was of the opinion that in West Bengal some preference hypothesis prevails. According to her experience, mothers-in-law allow their daughters-in-law to go in for sterilization only after a son is born. But she also found in her fieldwork that couples in the younger age groups do not care so much for sons.

Another very important issue of population stabilization programmes was also raised. A participant pointed out that population education should also contain lessons on the impact of overpopulation, on use of land, generation of income, health etc. A knowledge of such ecological and economic consequences of overpopulation, if imparted to young children, will have a good impact, she felt. The positive role of films as a medium of education in rural areas was also discussed. Cinema is a very effective instrument for critical transformation, it was felt.

It was observed that, at present, the village-level family welfare organizations and agencies do not work together. There is a need for coordination among them. The importance of mobile vans, the

idea being that services should be taken to mothers and not vice versa was emphasized. Entertainment should also form a part of village level family welfare programmes.

A participant made the important observation that, as of today, voluntary organizations — at least those working for women's health and development — were not represented on important committees and the Planning Commission.

A VHA representative from Madhya Pradesh pointed out that even today all family planning and family welfare programmes are institutional in character. They are not perceived as a people's movement. Therefore, family planning has not reached the grassroots.

It was felt that voluntary organizations are doing useful work. They should be allowed to frame their own policies and programmes depending on the characteristics of the areas where they operate. For the success of these organizations and for enabling them to enlarge their area of operation, they should collect committed community-based youth workers. Demonstration camps should also be held frequently.

The chairperson referred to the divergence between point 13 (family planning) of the new Twenty Point Programme and the family planning programmes of the Ministry of Health and Family Welfare.

The Twenty Point Programme continues to be based on targets set by the bureaucracy. The Ministry of Health and Family Welfare seems to be reluctant to be involved with voluntary organizations.

He proposed that half the budget for family planning should be earmarked for non-Governmental organizations and that the comparative performance of the Government and the non-GOs should be assessed by independent agencies.

He suggested that the recommendations of the Ramalingaswamy Committee report, Health for All : An Alternative Strategy, should be implemented.

A participant said that the minds of Indian bureaucrats should be decolonised. She endorsed the points made by the chairperson.

A nurse participant suggested that the Government should provide funds to voluntary organizations for research on natural family planning methods.

Another participant said that the Government programmes are all target-oriented and not process-oriented that is why funds for such activity as research on natural family planning methods are not provided.

The delegate from the Family Planning Foundation, appreciating the difficulties of voluntary organizations, called for introspection by them on their own failures. Many voluntary organizations, she felt, were not doing as well as they ought to.

This is particularly true in respect of family planning. These organizations should treat family planning as maternal-cum-child health programmes in which the question of spacing is taken care of. She was of the opinion that all methods of family planning including natural methods, should be propagated. The cafeteria approach is absolutely essential, she added.

A member of Parliament attending the meet opined that, on the whole, the non-Governmental Organizations were doing very well.

The real problem in the population stabilization programme was that family planning methods were not known precisely to those who were in real need of them, like the landless labourers, the slum-dwellers and the tribal people.

He did not approve the idea of banning the employment of child labour because that would mean more hardship to the poor families. He, however, stressed the importance of providing school education to them without stopping them from earning.

He felt that economic development is a pre-condition for population stabilization.

He particularly emphasized the role of audio-visual methods of propagation of family planning programmes.

The UNDP delegate pointed out that the family planning programme in India emphasized sterilization. The role of agencies like UNFPA is somewhat inconspicuous here because of the administrative culture of the Government, which is evident in schemes like the 'model plan' which has very little flexibility. Such schemes often inhibit innovations in the family planning programme.

Another participant pointed out that it was not true that the Government allowed the use of new contraceptives without proper testing. All the contraceptives in use in India were properly tested at the Government laboratories before being released in the markets.

Conclusions of Group E on Population Stabilization

During the discussion, there was an agreement that the existing Government rules regarding financial aid to voluntary agencies for doing family planning work needed drastic modification. Otherwise, voluntary family planning agencies would not come forward to do this work. Specific recommendations were made in this regard.

The group endorsed the recommendations made in this regard earlier by the Family Planning Foundation in toto.

The recommendations of this group are as follows:

1. The greatest need today is for the Government and the non-Governmental Organizations to work together and reinforce each other's strength. This calls for more effective representation of voluntary agencies in planning and decision-making processes from the national level to the local level (district/tehsil).
2. As indicated in the health policy statement, "a restructuring of the health services" is urgently called for, but this is not enough. There should be a more fundamental restructuring of the approach to family planning so that it is not restricted to the sphere of health alone but takes into consideration the socio-economic aspect also.
3. As far as possible, all voluntary agencies should have an adequate family planning input as an integral part of their work. Conversely, family planning activities in the country, both Governmental and voluntary, should have a suitable development input over and above family planning service input.
4. In regard to the present rules followed by the Ministry of Health and Family Welfare, Government of India, for giving financial aid to voluntary organisations, the following modifications were suggested -
 - (i) A voluntary organization should have complete freedom and flexibility to design its projects in accordance with its own understanding and innovative ideas.
 - (ii) The duration of each project should be from three to five years.
 - (iii) Their work should be evaluated by an independent, academic, non-Governmental agency and not by the Department of Family Welfare.
 - (iv) The present rigid schematic pattern (in terms of cases of sterilizations etc.) should be given up in favour of flexible programming to achieve the defined goals.

(v) Some suggestions from the Family Planning Foundation -

Need to examine how funding for non-Governmental Organizations' work can be sectorally coordinated, so that the resources available in the system can be dovetailed for maximum impact in the community and also the resources needed to prepare a community for family planning or the build-up of rapport through a service of their felt needs such as economic, general health etc.

Need for grants to be given for flexible programming but with defined goals, as opposed to the rigid schematic pattern prevailing at present.

Release of funds to be staggered across the year as opposed to the present year-end clearance of unutilised funds which is counter-productive to meaningful work.

Need to explore how the Government can help with mechanisms that can give aid to non-Governmental Organizations to develop viable project designs, organise monitoring, evaluation and proper accounting and book-keeping procedures and altogether support professionalisation of voluntary services and activities.

Explore ways in which voluntary organisations can participate in developmental decision making.

The present pattern of assistance is rigid and restrictive and lacks sensitivity to the reality of what can be done in the field. Centrally formulated schemes for urban family welfare centres, rural centres, support for sterilization beds, etc. have been worked out and voluntary organizations wanting Government support are expected to conform to these requirements spelt out for them. This makes for a mechanical involvement. There is need for a different approach that would allow organizations to assess their own needs and requirements to make their infrastructure subserve the population cause.

The Government budget for the voluntary sector in general and in particular for innovative experimental work needs to be greatly enhanced. Each district should have one pilot experimental project with a leading non-Governmental Organization in the area to demonstrate what can be done through a partnership concept.

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Panel Coordinator : Dr Ashish Bose

Rapporteur : Dr Suresh N. Kulkarni

MEMORANDUM SUBMITTED BY THE
VOLUNTARY HEALTH ASSOCIATION OF INDIA TO THE PRIME MINISTER

Mrs Indira Gandhi,
Prime Minister of India,
New Delhi.

May 6, 1983

Madam Prime Minister,

The Voluntary Health Association of India, together with the All India Women's Conference, recently sponsored a seminar to study the Government's statement on the National Health Policy, which was tabled in Parliament during its winter session in 1982.

The importance attached to this exercise can be gauged from the fact that there were 110 participants from all over the country, representing several voluntary organizations.

The gathering expressed its appreciation of the emphasis given to the voluntary sector in the implementation of the programmes envisaged in the policy statement. However, it was noted that no suitable mechanism exists for continuing the dialogue between the Government and the voluntary sector. In the absence of such a dialogue, there is the inevitable overlapping of programmes, differences of priorities, and absence of coordinated efforts.

The gathering strongly felt that voluntary organizations should be taken into confidence at the earliest stages in the formulation of such programmes. Voluntary organizations are not happy at being requested to implement programmes which they had no opportunity to help formulate.

It was repeatedly emphasised that, having close contacts with the operational (or grassroot) level, the voluntary agencies can provide more accurate data and project more realistic objectives. Moreover, the spirit of dedication to service of the poor and the non-commercial, non-bureaucratic approach to people invest voluntary action with a quality that is unique.

It was strongly urged, therefore, that the Government should treat the non-Governmental Organizations as valuable partners in the national effort to provide health for all by the year 2000 AD.

In order to achieve a mutually satisfactory partnership, it was suggested that a joint consultative machinery be set up at the central as well as the state levels and regular meetings be scheduled to review programmes, consider problems of implementation and otherwise facilitate cooperation between the official machinery and the voluntary sector.

If an early positive decision is made on this request, it will enhance the confidence of the voluntary agencies in the serious intention of the Government to associate the non-Governmental Organizations in implementing urgent programmes of national importance.

We will appreciate early action to realize this joint consultative committee.

We are aware that you yourself have openly and strongly advocated the active participation of voluntary bodies in the health care programme of the Government. Our request is only that this collaboration be brought about early and in a systematic way through a clearly defined mechanism.

We will send you a more detailed report on our meeting very shortly.

With expressions of our highest regards, and assuring you of our cooperation, we remain, Madam Prime Minister,

Yours sincerely,
for The Voluntary Health Association of India

Sd/- Avertanus L.D'Souza
Executive Director

OUR THANKS

The organizers are beholden to the Voluntary Health Association of India for sparing the services of one of their staff to assist in the planning, the execution and the follow-up of the seminar on the National Health Policy, and for the use of stationery and duplication facility at the VHAI.

The organizers are grateful to the President of the Voluntary Health Association of India, Dr Harbans Dhillon, for chairing the inaugural function and for her inspiring address.

We are also thankful to Mr Averthanus D'Souza, Executive Director, VHAI, for conducting the closing function so smoothly.

Our gratitude to Mrs Anjuman Wahabuddin Ahmed, Vice President, All India Women's Conference for having travelled all the way from Hyderabad to make the AIWC representation at the seminar complete.

The organizers also thank individual members of the Steering Committee, who, in spite of being hard pressed for time to complete their normal official work, nevertheless, kept their promises and brought briefs which served to enlighten all those present at the sessions. Their initiative in highlighting important issues at the meetings is deeply appreciated.

We are grateful to Dr Indra Bhargava, Deputy Director (MCH), in the Ministry of Health and Family Welfare for the slide-show he presented to make us fully knowledgeable about the systems followed in assessing and improving the Mother and child Health Programme.

We thank the authorities of the India International Centre for making available their conference room, for three consecutive evenings, to conduct the meetings of the Steering Committee.

We are also impressed by the response of the officials of the Health Department of the Delhi Municipal Corporation and the Metropolitan Council of the Union Territory of Delhi. We are indeed very grateful to them for their total cooperation.

We take this opportunity to record our appreciation of the gesture by the Chief Executive Councillor of the Delhi Metropolitan Council, Shri Jag Parvesh Chandra, who entered the seminar hall silently, occupied a rear seat and listened in rapt attention to the conclusions of the various groups. When escorted to the dais, and asked to speak, he concluded the remarks in exactly five minutes. It was heartening to receive his wholehearted appreciation.

It is not easy to name all who provided us resources, and the participants who responded so spontaneously and warmly to our effort. They came from long distances. As if understanding our

constraints, they made no demands on us whatsoever. This was a memorable experience of collective discipline springing from shared interest and trust. Our thanks to all of them.

We must thank Prof M.G.K. Menon, member of the Planning Commission and others who have written to the Convener expressing their sustained interest in the education of voluntary organizations about the implications of the National Health Policy and their role in implementing it. Their keenness to support this educational effort reinforces the faith that health will one day become the first priority in the people's lives, so that they will take the responsibility of ensuring healthy lives for all in their own hands.

Our gratitude is due to the Institute of Haematology, New Delhi, which provided the meals and snacks to the participants. These were served in the AIWC canteen promptly at the three limited intervals.

We thank the media representatives who focussed public attention on the issues discussed in the seminar.

The staff of AIWC must be generously thanked for their interest in the seminar, and their quiet but effective support which enabled the discussions to run smoothly.

Although individual letters thanking everyone have been sent, we feel this report will not be complete without recording our thanks to them once again here.

Smt Kunti Sondhi,
All India Women's
Conference

Mahendra Kulshrestha,
Concern for Correct
Medicine

Smt Purabi Pandey,
Voluntary Health
Association of India

WHAT THEY SAID.....

While planning this seminar, our main endeavour was to focus public attention on the Statement of the Government on the National Health Policy and to stimulate discussion on the important issues contained therein.

The participation in the seminar-both numerically and qualitatively-was far beyond our modest expectations. The variety and richness of experiences drawn together made this seminar an historic occasion. It was also unique in that it brought together on a common platform Government officials, non-Governmental organizations and academics.

The media played a significant role in disseminating the issues focussed upon.

Said The Statesman (April 24, 1983):

"The National Health Policy, which envisages health for all by 2000 AD, should give priority to primary health care and concentrate on steps to prevent diseases especially in the rural areas.

"This was one of the recommendations made at a seminar on the National Health Policy organized by the Voluntary Health Association of India, the All India Women's Conference and the Concern for Correct Medicine in New Delhi on Saturday.

"Briefing reporters after the day long seminar, Mr A.L. D'Souza Executive Director of the VHAI said, the seminar discussed at length the priorities mentioned in the National Health Policy and it was felt that the job of providing 'health to all' by 2000 AD was far too big either for the Government or the voluntary agencies to handle alone. The seminar had, therefore, recommended that a machinery should be set up to coordinate the work being done by the Government and voluntary agencies."

Indian Express (April 24, 1983) reported that the seminar participants had urged mandatory output of vital drugs.

"...the groups urged that the Government involve voluntary agencies at every level. In her keynote address, the VHAI president, Mrs H. Dhillon suggested the Government appoint persons to coordinate implementation of the policy at district and state levels.

"The seminar felt that if the Government's priorities were right, resources were not a constraint. It pointed out that the non-Governmental sector also needed to watch its priorities."

The Hindustan Times (April 24, 1983) went on to say:

"Enormous expenses incurred by the Government and the private sector on highly professionalised medical services to cater to a

microscopic section of the population was criticised by several participants...

"Irrational expansion in pharmaceutical production at the cost of essential drugs, and the target-oriented approach to the population control-programme also came up for criticism at the seminar."

In a PTI feature prominently published by Patriot (June 10, 1983) Kamala Mankekar who was a participant wrote:

"There is urgent need for medical literacy among the people if they are to be saved from harmful, often irreversible, effects of some of the modern drugs. With relentless promotional campaigns many of the brands of such drugs have become household names, and gullible citizens, seeing easy remedies in these patents, consume them without being aware of the hazards they are exposing themselves to..."

"Not only the lay consumer, even the medical practitioners need to be fully informed of the often concealed or vaguely mentioned side effects of many patent drugs..."

"The practice of supplying necessary literature with patent drugs formulations seems to have disappeared in the name of reducing production and packing costs; and the people who, in the face of mounting cost of medical consultation, are indulging more in self-medications are increasingly exposed to the hazards of dangerous drugs..."

"According to VHAI sources, even when Government restricts or bans the sale of a particularly dangerous drug, the implementation of the decision is neither swift nor complete."

National Herald added:

"In gruelling day-long discussions and deliberations in the seminar by about 100 representatives of voluntary organizations on health and other social welfare agencies from all over the country, a concerted effort was made to assess the present national health policy and recommendations were made..

"Taking part in the concluding session of the seminar, the Chief Executive Councillor, Jag Pravesh Chandra, said that it was easier for the Government organizations to do social work than by the voluntary organisations for whom the social work is as selfless as a mother caring for a child"

Issues

One participant drew attention to issues she felt were of vital importance.

They were:

1. Implementation of the National Health Policy by an active and creative partnership with voluntary organizations in the following areas:-

(a) Family planning, (b) maternity and child care, (c) education of people based on medically valid and socially acceptable information, (d) a critical survey of the various methods used in family planning.

Immediate measures for (a) making drinking water available and saving the rivers from further pollution (b) tree plantation and afforestation (c) eliminating the use of dangerous pesticides.

The doctors and licensed chemists to be kept well informed regarding (a) drugs that have been banned (b) the essential drugs list recommended by the WHO and the Health Commissions to be followed scrupulously (c) a national coordinating health agency to be promoted with the help of voluntary organizations (d) to ensure that essential and life saving drugs are available to the people, especially the poor and those who are in remote rural areas.

Indicators to evaluate the nutritional status of people within primary health care services (b) to emphasize feeding programmes (c) to improve the nutrition content, quality and quantity-wise, of primary health-care services for the people in the peripheral areas.

- Anima Bose

Extracts from letters

"I sincerely feel that the seminar on "The Health Policy" was very well organised and the outcome is very useful" - M.I.D. Sharma.

"The seminar was well organised for which a lot of efforts were put in. But still I feel that the seminar could be much more useful, had only a few selected and topical health problems been discussed in available time instead of consideration of the National Health Policy, with its vast dimensions" - S.L. Chaddha

"On the whole I was very impressed with the level of discussion"

- Susheela Bhan

"...Most of the Government programmes are target oriented and hence, the process-oriented programmes are not favoured by the Government. Any community action requires a pace which is very slow and a voluntary agency working with the people has to work at a speed which people can cope up with because changes do not take place overnight. Hence, sometimes it so happens that at the end of one or two years of work, a voluntary agency may not be able to show any tangible results (e.g. so many F.P. operations done) but may have done a pioneering work of community building and organising around health and other issues.

I am thankful to you and the VHAI for giving me an opportunity to meet people and exchange views with them about the healthcare activity." - Ranna Shah

"...on the whole, I found the seminar most interesting, enlightening and very useful. The opportunity of meeting the others is also highly appreciated, as it helps us to get to know and understand each other's problems and efforts that are being made by various organizations.

"The view expressed at the seminar are also interesting and helpful but I wonder whether discussions at such seminars could be geared to more actual working situations. In other words, if the participants are presented with information on how a specific project is being actually implemented in a village or specific area e.g. how health education is being implemented in a village, the methods used, how the organization is done, to what type of target group, the outcome or the result achieved, if result is not satisfactory, what are the possible reasons. By bringing up these situations the participants will be motivated and encouraged to query and suggest possible practical solutions geared to actual working situations. I personally feel that this will be very helpful to the participants who are actually implementing programmes in their respective institutions or areas." - *Kasang Y. Takla*

"Very commendable effort indeed...

"Time allotted for discussions was too limited. At least three days would be required which would also include finalization of the recommendations for presentation.

"It would have been more ideal if one topic was discussed at one time so that contributions would come from all the distinguished participants and then the other topics could be discussed. On the basis of all the discussions the final recommendations could be made." - *Indu Kapoor*

"I appreciate your concern regarding the contributions made by the participants at your seminar on The Health Policy.

"I would like to congratulate you and your colleagues on the success of the seminar and also the arrangements in connection with it. I do hope when you send in your report to the Planning Commission and the Health Ministry, they will pay heed to the recommendations of the seminar." - *Sham Mohini Pathak*

"The seminar arranged by your Association and All India Women's Conference was really worth attending. It was very educative because so many organisations took part and sat in five groups in the same hall.

"It was a very well organised seminar. We enjoyed it." - *Krishna Chawla*

"The one day seminar on the Health Policy really proved to be a busy schedule for all the participants from 41 institutions." - *P.T. Sukhatme*

"...wish the seminar every success." - *Dr W.V. Rane*

"Owing to old age and the heat, I am unable to participate, but I send you my best wishes for its success." - *Prahlad Das*

An Area Concept in Medicare

*Dr K.S. Sanjivi**

A statement of the National Health Policy was tabled in Parliament by the Ministry of Health on November 2, 1982. Similar statements, issued in 1979 and in 1980-81, were discussed by the Central Council of Health at its sixth and seventh meetings.

The November '82 statement, therefore, was studied along with the earlier statements to note any marked differences among them.

Since the preparatory National Conference on Primary Health Care, called by the Ministry of Health in November, 1977, and the Alma Ata Declaration of September, 1978, the emphasis in all medical literature on community health as well as in Government resolutions has been on primary health care.

CH HERITAGE

The 1982 policy statement starts with a short account of our "rich centuries old heritage of medical and health science" and discusses briefly the "progress achieved and the existing picture".

Naturally, the stress is on the development of health service infrastructures that have been included in the Prime Minister's revised Twenty Point Programme. As a matter of fact, the omission of references to health in the earlier Twenty Point Programme were brought to the notice of the Prime Minister as early as January, 1976.

The implementation of the policies laid down in the white paper requires total commitment, on the part of the bureaucracy and the people themselves; to the political will that has been displayed by the policy makers.

The persisting apathy on the part of the public in matters of health is truly deplorable. This article is, therefore, an attempt to draw attention to the failures in implementing the health policy, implementation being still confused and tardy.

IMARY HEALTH CARE

We have reiterated in many forums that the essential requirements of 'primary health care in India are as follows:-

A health post manned by a lay first-aider (or village health guide) for every 1,000 people;

a male and a female multipurpose worker for every 5,000 people;

a doctor, made available at all mini health centres, for at least three hours a day, three days a week;

the identification of, and liaison with, a referral hospital at a reasonable distance.

The exact role and importance of the village health guide or lay first aider, as well as the absolute necessity for the input of the part-time doctor at the subcentre level, have already been explained several times.

I have attended almost every national conference on community health care organised by the Ministry of Health, the Planning Commission, the Indian Council of Social Science Research since 1971.

In fact, the first ever National Health Seminar focussed on community health, was organised by Dr Durgabai Deshmukh and this writer in 1965 at Madras.

The first official meet to discuss rural health care was held when Prof D.P. Chattopadhyaya was the Minister of Health. An impossible idea of identifying more than 3,00,000 practitioners of indigenous medicine and giving them a quick orientation in modern medicine died a natural death, although more than Rs.150 crores had been provided for the purpose in that year's budget.

IN TAMIL NADU

It is often said at meetings in Delhi that the Tamil Nadu Government has not accepted the community health volunteer or health guide scheme.

Yes, the Tamil Nadu Government did not accept it in the way it was presented in 1977 by the Union Government which smelt too much of potential political interference. But, the concept of a permanent resident housewife in a village, given initially a four weeks orientation and later continuous in-service training, to serve as a friend of the community, at the interface between the multipurpose workers, where the official hierarchy ends, and the community where the problems arise was recognised and introduced in Tamil Nadu much before October, 1977. The lay first-aiders, as we call them in Tamil Nadu, are an essential part of the mini health centres run by the voluntary agencies which have received official support and approbation. So it is wrong to say that the Tamil Nadu Government has rejected the recognition of the importance of village health guides.

REFERAL HOSPITAL

It has already been pointed out how a referral hospital is an essential component of the community health organisation.

Here again, the Tamil Nadu Government issued categorical orders, as early as 1978, instructing all Government institutions at the taluk, district or teaching level to honour every reference from a mini health centre by attending to the cases promptly, sending a clinical report on such referred cases to the health centre concerned.

and maintaining a record of all such referrals.

However, these laudable instructions are hardly respected by the institutions involved which is yet another instance of failure in implementation.

The health policy statement rightly insisted that "the location of curative centres should be related to the populations they served, should be properly dispersed and regional imbalances avoided."

We have also always insisted on an area-concept whereby every health facility, be it a subcentre or referral hospital, should serve every family around it, irrespective of the occupation of the head of the family.

Institutions serving only certain occupational groups such as the Employees State Insurance hospitals or the proposed Central Government Health Scheme hospitals are luxuries that a poor country such as ours can ill afford, nor do they serve those, such places are intended for efficiently, because of the distance many of them may have to travel to reach the specifically earmarked institutions for them.

COMMUNITY PARTICIPATION

The need and advisability of adequately utilising the services of private voluntary organisations active in the health sectors, as well as the recognition of the fact that no programme for health care succeed without community participation have been highlighted in at least half a dozen places in the document.

Part of the Health Ministry's document health for all by 2000 AD approved by the Central Health Council in June, 1981, reads as follows:-

.....in the implementation of the proposed strategy a growing burden will have to be shared by the voluntary organisations and private practitioners in the field of health care. It is accordingly recommended that every State Government may devise viable mechanisms to offer suitable incentives as well as financial, technical, infrastructural support to such organisations/persons through scheduled banks or otherwise. The community should also be encouraged to organise primary health care facilities in the rural areas, slums, etc.

"For efforts, as in para 34, the smallest unit may be of 5,000 population (the coverage of a sub-centre). In such areas, the Government may not extend its organisational structure; instead it should provide financial support equal to 75 per cent of the non-recurring and recurring cost which Government would have incurred on its health set up in that area or 75 per cent of the total expenditure incurred by the voluntary organisation/community, whichever is less. Such organisations should get the same technical, referral, etc. support from the Government organisations as is provided to the Government-run sub-centres".

However, there is apparently no categorical advice by the Centre for the involvement of voluntary agencies while communicating the 100 per cent Central financial sponsoring of sub-centres serving 5,000 population each.

In most states, the Governments seem to believe that they can "deliver" health, regarding the people as passive recipients of gifts from their superiors.

This will never work. In Tamil Nadu, the 246 mini health centres which fulfil all the requirements of a sub-centre and have additional inputs of record keeping, a doctor being available at the sub-centre and have additional inputs of record keeping, a doctor being available at the sub-centre on three days a week, etc. are yet to receive the financial assistance offered by the Union Government. Unless the bureaucracy changes its attitude of distrust and disdain of voluntary agencies, the platitudes in successive policy papers will naturally not be accepted and the policy will remain unimplemented.

The policy paper has also underlined the vital importance of ensuring effective coordination of the integration of all plans for health and human development, rural development, agriculture, food production and distribution, adult literacy, housing, sanitation, environmental hygiene, regulation of manufacture and sale of drugs, etc.

Here I would like to insist that the Health Department and the private voluntary health agencies should concentrate on community health, leaving other activities enumerated above, however, important they are for good health, to the Rural Development and the Social Welfare Departments. At the moment there is enormous confusion and overlapping of programmes resulting in both unsatisfactory implementation and wastage of public funds.

When the several ministries agree to work in coordination giving up their own individual empires, the Rural Development Department should concentrate on water supply and sanitation, environmental hygiene and proper organisation of effective employment generation (or food for work projects) to increase the purchasing power of the families.

Upgrading of selected rural dispensaries, to become "subsidiary health centres" has been recommended by the Union Government. But there seems to be no special virtue in creating more primary health centres within a block so long as the sub-centres are organised on the concepts of the mini health centres that is to include the input of a part-time doctor at the sub-centre.

Rural dispensaries are run in Tamil Nadu by the Rural Development Department and more than 1.6 crores rupees are spent annually on different types of rural dispensaries. As pointed out elsewhere, medical care should necessarily come entirely under the health department. So long as this is not done, primary health care cannot be achieved.

L. WELFARE

The Social Welfare Department could ensure the success of local projects for kitchen and community gardens, milk production and all poultries which are so essential for making possible proper nutrition. Some of these, which started under the UNICEF assisted applied nutrition programme in the Sixties, have not been maintained properly.

Likewise, the Social Welfare Department could launch projects that will restore old family ties and traditional sharing of basic needs like food and shelter so that paediatric and geriatric problems alike in rural communities can be solved on a domiciliary basis (not on costly, remote Western type of institutional arrangements).

Thus a remarkable impact can be made on social welfare. These models should clearly be based on our own ancient history and culture and at a cost the country can afford to replicate far and wide.

Indeed medical sociology has hardly received any attention in India, and obviously, this is a study which should be made entirely in the local context.

When considering primary health care in urban areas and Madras as examples there appears considerable overlapping and wastage of scarce resources. Building and equipping a peripheral urban hospital at Perambur (in Madras) at a cost of 1.71 rupees crores is not in tune with the present concepts of relative monetary inputs between urban and rural areas.

The numerous corporation dispensaries, dispensaries run by several voluntary agencies (denominational and secular), the proposed centres under the Madras Metropolitan Development Authority/World Bank projects; the Integrated Child Development Schemes and those under the new residents' welfare trust of the Slum Clearance Board should all be brought together under a uniform scheme which will emphasise prevention in its widest scope and not merely cure on a symptomatic basis. It is regrettable that one more of the old, elsewhere discarded, model of a "dispensary" has been opened by the Madras Corporation in Saidapet, to add to the many "dispensaries" that already exist in the same locality. These, offering cure on a symptomatic basis for all illnesses, can mislead the illiterate public and do more harm than good with neither an efficient referral system nor a preventive bias.

NUTRITION

The section of the statement dealing with nutrition, says how organised efforts to improve the purchasing power of the poorer sections of the society should be the urgent concern of the authorities.

The section of the statement dealing with nutrition says how organised efforts to improve the purchasing power of the poorer

sections of the society should be the urgent concern of the authorities.

The concepts of protein lack and protein-calorie malnutrition have in recent times given place to just calories deprivation; that is, given the ordinary vegetarian food in adequate quantities malnutrition will cease to be a major problem. That is why we welcomed earlier the bold action of the Tamil Nadu Government in launching the Rs.100 crores feeding programme notwithstanding the numerous problems in implementation.

It was pointed out that the Government should somehow make a success of the programme and that the country itself should provide the support instead of depending on foreign aid. This takes us to another example of duplication of efforts happening in eight districts of Tamil Nadu, thanks to the World Bank and the Danish International Development Agency (DANIDA) offers.

BAN ON PRIVATE PRACTICE

The health policy statement also urges the State Governments to do away with the system of private practice by medical personnel in Government services. The situation in the earlier decade of the century was such that Government Medical Officers had to be available for serving the public outside the Government institutions because there were not enough doctors in the private sector; that is no longer true. Therefore, the States should definitely make every doctor in their employment a full-time employee and make his salary and allowances equal to the other categories of permanent civil service.

Two recommendations which did not find a place in the earlier health policy statements are (1) importance of health education and (2) a "well conceived health insurance scheme on a Statewide basis".

A third topic, briefly referred to in earlier policy statements and again mentioned is the need for "the building up of a well conceived health information system", on which alone the health manpower requirements could be planned in the future. On each of these three subjects, health education, health insurance and health information system, a considerable amount of literature is available. In fact books have been written on these. Let us briefly consider these.

NON-EXISTENT PROFESSION

(1) Health education -- Briefly the objects of health education are (a) to educate people and alter their behaviour where necessary to promote and maintain their health, (b) to impart the minimum knowledge required for people to be aware of the factors that effect health and recognise the early symptoms of disease; (c) to assure the people of the availability of the needed services and the accessibility of those services to the poorest family.

It has been shown that it is comparatively easy to achieve success in situations depending on techniques like vaccinations and mosquito control. But where techniques play only a minor part and the people require to be persuaded to change their habits, the situation becomes much more difficult e.g. choice of correct food, smoking and family planning.

A health education specialist is a profession practically non-existent in India; it is questionable whether we can afford a new category; every health worker should, therefore, be also a health educator.

KERALA

Health education cannot obviously succeed without general education based on literacy. It is well known that Kerala has an infant mortality rate of about 40 against the national average of 33 and a death rate of six against the national average of 14. On the other hand, Punjab, which is a richer State than Kerala, has not been able to produce these spectacular achievements in health statistics.

The villages and cities being a continuum resulting in the better dispersal of medical institutions, so that primary care has always been available has been offered as a reason in support of Kerala's enviable record.

But to my mind, the real reason is the female literacy rate which is the highest in the country and indeed compares well with the developed countries. This added to the personal cleanliness of the individual and his surroundings (water, thankfully, being no problem) should be the overriding explanation.

This underlines the most important aspect of health care, that it cannot be "delivered" but it is a "do-it-yourself" proposition to which every individual should be committed.

It is time that the Governments in every State in India realised that official actions alone, much less the mere issuing of annual health policy statements cannot produce any impact on the nation's health.

Who is in need of health education? Every citizen from the Prime Minister to the three-year old child in the most remote village; only the content will vary.

Who should give health education? Every person who knows should teach every one among his contacts. For example, the business executive who undergoes vasectomy because he cannot afford a third child on his meagre monthly income of Rs.3,000 should take a personal interest in all his poor servants, neighbourhood slum dwellers and motivate them to accepting sterilisation procedures identifying and helping every one in need is everybody's business, not merely that of official health workers.

Here, one should insist that the NSS volunteers, in the colleges all over the country, should be given an orientation on health

maintenance and employed to spread the knowledge to urban slums and rural areas in a systematic, planned programme. Using the students to make roads is misuse of valuable, intelligent manpower it is not the road to better health.

PREVENTION

(2) Health Insurance — Health insurance often means sickness insurance.

But, in a poor country like India, the emphasis should honestly be on prevention and therefore the pre-payment should cover every aspect of personal preventive measures apart from cure of serious illness. The ESI and the CGHS for its employees are the only two pre-payment plans now operating in India.

Some business enterprises have arrangements with private insurance companies to cover only the highest category of business executives. All the above plans are compulsory, restricted to certain groups, emphasise cure rather than prevention and in the case of the ESIs and the CGHS are heavily subsidised by the Governments.

While people in India now understand insurance against death, they do not yet recognise the need for pre-payment towards prevention and treatment of illness.

In the US, hospital care and surgery have become so costly that insurance in Blue Cross and similar plans has become almost universal. In the UK, the only democracy which has socialised medicine, persons insuring under plans outside the National Health Insurance and the amount spent on such insurance have both been increasing steadily during the last decade.

FIRST OF ITS KIND

The Voluntary Health Services pre-payment plan, the first of its kind in India, contemplates a small contribution of about 0.75 per cent of the family's income to enable the maintenance of health records of every member of the family, to take preventive action (immunisation, child care, and antenatal and family planning advice). The annual subscription for the entire family varies from Rs.12 to Rs.300 as the income ranges from the poorest to the richest.

For subsequent needs such as hospitalisation, investigations and surgery, further charges must necessarily be made. These charges again are not uniform for everybody; but are related to the patient's ability to pay, in other words, the principle is to take from every family what it can afford but provide, on every occasion, the services demanded by the medical needs, totally regardless of the quantum of contribution paid.

It is impossible to decide on any definite practical scheme in the absence of reliable morbidity data and actuarial information. But it is equally imperative, considering the costs of medical care that some pilot projects, evolved by non-profit health agencies should be encouraged by the authorities. The American experience has shown that medical costs have escalated more than twice the rate of inflation registered in other areas.

The difficulties discussed so far in evolving a plan of health insurance take us to the next topic of a reliable health information system.

AMPLE PROFORMAE

(3) Health Information system - The system should be built on a permanent basis and not on sporadic ad-hoc surveys carried out here and there.

The attempt to get 100 per cent reliable data to satisfy the scholarly statistician is bound to fail. The Indian Council of Medical Research should evolve simple proformae which could be completed at all levels starting from the health post at the extreme periphery (1,000 population level) and including the medical college hospitals.

The mechanism for the retrieval of information from these proformae can be worked out by the Institute of Research in Medical Statistics, a wing of the ICMR. An exercise on these lines throughout the country will certainly tell us very soon qualitatively what is happening where, though quantitatively it may not be 100 per cent accurate.

The urgent implementation of primary health care, with its village health guide and multipurpose worker at the 1,000 and 5,000 people levels; and obtaining the community's cooperation and confidence will provide the infrastructure for the ICMR collecting valuable information on the health and disease status of populations, which after all is the ultimate aim of modern epidemiology.

An essential component of implementation is continuous monitoring and evaluation. When we talk of evaluation, people always start with the village health guide, whether she has visited all the 200 families in her village once a week as she is expected to.

It will be more appropriate to start with the evaluation of the knowledge, attitudes and perception of the top leaders of the community, the parliamentarians and legislators, the elected ministers and the full-time, paid bureaucrats. Studies to elicit the answers to the following questions will not only be revealing but of extreme practical utility in designing our future plans.

- (a) How much are they aware of the existing set up (inherited from the British), its actual working, deficiencies and remedies?
- (b) Considering that the set-up is totally old fashioned and not in tune with modern concepts of community health, how far are they willing to effect the necessary changes in the set-up?
- (c) Whether they are aware of the priorities for spending the health rupee; between primary health care and more and more sophisticated urban hospitals.

And so we end where we began, the face of India's health cannot change without implementing primary health care in every detail; and such implementation cannot be achieved without mutual understanding cooperation and trust between the Governments and the governed.

*Dr K.S. Sanjivi has been in the forefront of the voluntary health services working in the State of Tamilnadu.

He pioneered the mini health centres programme, now widely spread all over that State.

He also holds the position of Vice-Chairman Chidambaram Institute of Community Health, VHS Campus, Adyar, in Madras.

The above article was serialised in the Hindu of February 3 and 4, 1983.

The National Health Policy and Its Implementation

*Prof Debabar Banerji**

The Government of India's statement on national health policy, which was placed before the Parliament recently, is an interesting document.

It reaffirms the government's pledge to fulfil the promises the leadership had made to the people of India half a century ago. It is, however, difficult to find out from the statement how the government intends to overcome the obstacles which have come in the way of redeeming these promises in the past.

The 17-page statement starts with a reference to the Constitution of India which envisages the establishment of a new social order based on equality, freedom, justice and the dignity of the individual. It recalls that elimination of poverty, ignorance and ill-health forms the major plank of the Constitution. The Constitution directs the state to regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties.

After referring to the Five-Year Plans and decisions of the Central Councils of Health and Family Welfare and the National Development Council, the statement underlines the "rich centuries-old heritage of medical and health science of the country" and the progress achieved since independence in the form of elimination of smallpox and plague and decline in mortality rates and in the increase in the expectancy of life at birth.

Gloomy Picture

It then goes on to paint a very gloomy picture of the existing situation: the high rate of population growth continues to have an adverse effect on the health and quality of life of the people; distressingly high mortality rates for women and children, with almost one third of the total deaths occurring among people below the age of five years and an infant mortality rate of around 126 per thousand live-births; exceptionally high rate of malnutrition; high prevalence of communicable diseases; only 31 per cent of the rural population with access to pottable water supply; only 0.5 per cent enjoying basic sanitation; and only 30-35 per cent of deliveries conducted by trained birth attendants.

The statement is quite forthright in analysing the existing situation:

The existing situation has been largely engendered by the almost wholesale adoption of policies and establishment of curative centres based on the Western models, which are inappropriate

and irrelevant to the rural needs of our people and the socio-economic conditions obtaining in the country.

The hospital-based, disease and cure-oriented approach towards the establishment of medical services has provided benefits to the upper crusts of society, especially those residing in the urban areas. The proliferation of this approach has been at the cost of providing comprehensive primary health care services to the entire population, whether residing in the urban or the rural areas.

Furthermore, the continued high emphasis on the curative approach has led to the neglect of the preventive, promotive, public health and rehabilitative aspects of health care. The existing approach, instead of improving awareness and building up self-reliance, has tended to enhance dependency and weaken the community's capacity to cope with its problems. The prevailing policy in regard to the education and training of medical and health personnel, at various levels, has resulted in the development of a cultural gap between the people and the personnel providing care. The various health programmes have, by and large, failed to involve individuals and families in establishing a self-reliant community.

Also, over the years, the planning process has become largely oblivious of the fact that the ultimate goal of achieving a satisfactory health status for all our people cannot be secured without involving the community in the identification of their health needs and priorities as well as in the implementation and management of the various health and related programmes. Based on the above contentions the statement asserts that the contours of the national health policy have to be evolved within a fully integrated planning framework which seeks to provide universal comprehensive primary health care services relevant to the actual needs and priorities of the community at a cost which the people can afford, ensuring that the planning and implementation of various health programmes is through the organised involvement and the participation of the community, adequately utilising the services being rendered by private voluntary organisations active in the health sector.

However, as it proceeds further, the statement mixes policies with programmes. It points out that the revised Twenty Point Programme gives a high priority to the promotion of family planning as a people's programme, on a voluntary basis; it asks for substantial augmentation and provision of primary health care facilities on a universal basis; it calls for control of leprosy, tuberculosis, and blindness; it involves acceleration of welfare programmes for women and children and nutrition programmes for pregnant women, nursing mothers and children, specially in the tribal, hill and backward areas.

The Twenty Point Programme also places great emphasis on the supply of drinking water to all problem villages, improvements in the housing and environment of the weaker sections of society, increased production of essential food items, integrated rural development, spread of universal primary education and expansion of the public distribution system.

phasising the importance of population stabilisation, the statement refers to a separate National Population Policy. Similarly, the need for restructuring of medical and health education has led to the formulation of a separate National Medical and Health Education Policy.

Recommendations for Restructuring

to put an end to the existing all round unsatisfactory situation, the Statement underlines the urgent necessity of restructuring the health services around the following broad approaches:

- To provide a well disbursed net-work of primary health care services which takes into account the fact that a large majority of health functions can be effectively handled and resolved by the people themselves, with the organised support of volunteers, auxiliaries, paramedics and adequately trained multipurpose workers of various grades of skill and competence, of both the sexes.
2. Large scale transfer of knowledge, simple skills and technologies to Health Volunteers, selected by the communities and enjoying their confidence.
3. Positive efforts to build up individual self-reliance and effective community participation.
4. Back-up support is provided to primary health care through the establishment of a well worked out referral system at "the various levels of organisational set-up nearest to the community."
5. Establishing a nation-wide net-work of sanitary-cum-epidemiological stations to tackle the entire range of poor health conditions on a wide front.
6. Full utilisation of untapped resources by encouraging the establishment of practise by private medical professionals, increased investment by non-governmental agencies in establishing curative centres and by offering organised logistical, financial and technical support to voluntary agencies active in the health field.
7. Planned attention to the establishment of centres equipped to provide speciality and super-speciality services through a well disbursed network of centres to meet the present and future requirements for specialist treatment.
8. Special efforts to offer mental health and medical care and physical and social rehabilitation to the disabled.
9. First priority to be accorded to people living in tribal, hill and backward areas and to populations affected by endemic diseases.

The statement calls for development of a "Health Team" approach to health manpower development. It also recommends phasing out of private practice by medical personnel in government services. It advocates involvement of practitioners of various systems of medicine with the ultimate objective of bringing about a phased integration of the indigenous and modern systems of medicine.

Priority Areas

The statement also asks for a planned, time-bound attention to some of the more important areas. These are (i) nutrition; (ii) prevention of food adulteration and maintenance of the quality of drugs; (iii) water supply and sanitation; (iv) immunisation programme; (v) environmental protection; (vi) maternal and child health services; (vii) school health programme; (viii) occupational health services.

The statement goes on to underline the need for health education, management information system, strengthening of the medical industry and development of a statewide health insurance scheme for mobilising additional resources for health promotion and ensuring that the community shares the cost of the services in keeping with its paying capacity.

It asks for a balanced development of basic, clinical and problem-oriented operational research in the field of research. It also emphasises the vital importance of intersectoral co-operation between the health and its more related sectors, with the setting up of suitable mechanisms at the centre and in the states for securing intersectoral coordination in the fields of health and family planning, medical education and research, drugs, and pharmaceuticals, food and agriculture, water supply and drainage, housing, education and social welfare and rural development. There is also emphasis on the need for monitoring and review of progress of health programmes.

The statement ends by setting out the goals for health and family welfare programmes for the years 1985, 1990 and 2000. For the year 2000, it visualises the infant mortality rate to come down from the present 125 to below 60; crude death rate from around 14 to 9; maternal mortality rate from 4-5 to below 2; life expectancy at birth from 52.6 for males and 51.6 for females to 64 for both the sexes, crude birth rate from around 35 to 21; a net reproduction rate from 1.48 to 1.00. It has also set out specific goals for the family size, maternal and child health services including immunisation and for leprosy, tuberculosis, and blindness prevention.

The Government of India deserves to be warmly congratulated for its forthright disapproval of the existing situation which it says "has been largely engendered by the almost wholesale adoption of health manpower development policies and establishment of curative centres based on the Western mode's which are inappropriate and irrelevant to the real needs of our people and the socio-economic conditions obtaining in the country". The existing approach is considered as "hospital based", 'cure-oriented', serving 'upper crusts of society'.

in urban areas; it has tended to 'enhance dependency' and weaken the 'community's capacity to cope with its problems', and, there exists a "cultural gap between the people and the personnel providing health care." Introduction of policy issues of such far reaching significance unwittingly tends to make the numerous weaknesses and inconsistencies in the rest of the statement all the more glaring and obvious.

Weakness and Inconsistencies

Surely, the present planners and administrators cannot claim to be qualitatively any different from those who had been associated with development of health services in the past. Further-more, while such oft-repeated programmes concerning nutrition, prevention of food adulteration and maintenance of the quality of drugs, water supply and sanitation, maternal and child health, school health, occupational health, health education and health insurance find so much of space in the document, it contains little in the form of policy guidelines to bring about the necessary basic changes in the health administrative systems of various levels to close the cultural gap between the people and providers of health services.

What should be the relationship between generalists and specialists in health administration in India? What are the policy guidelines to ensure that the cadre structures, both at the Union as well as State levels, are developed in such a way that key positions in community health are filled by managerial physicians, who have the required inter-disciplinary competence to adopt an epidemiological approach to extend the outreach of community health services to the unserved and the underserved?

What are the policy guidelines to promote community self-reliance in health? Obviously, the 'above down' health education approach expounded in the Statement is not consistent with promotion of community self-reliance. The Statement has also ignored completely the vital question of regional imbalances in terms of health and health services. For instance, major policy directives are needed to deal with the alarmingly high mortality and morbidity rates in Uttar Pradesh and Bihar.

Again, at the level of specific programmes, the statement does not provide any policy frame to overcome the obstacles even in the major health programmes which have been included within the Twenty Point Programme.

Why is it that even though the felt-need oriented National Tuberculosis Programme is in operation in the country for over two decades, more than 80 per cent of infectious tuberculosis patients are still being turned back at various health institutions with nothing more than a bottle of cough mixture? Why is it that hundreds of thousand people are getting crippled because of leprosy even though a highly efficacious, inexpensive and nontoxic drug has been available for the past so many years.

In the field of medical research, the Statement rightly emphasises the need for a balanced development of basic clinical and problem-

oriented operation research".

However, what are the policy perspectives for attaining that balance? To what extent have findings from problem-oriented operational research contributed to formulation of key community health programmes of the country?

In a recent article in the Economic and Political Weekly, Roger Jeffer has pointed out that the Government of India is now much more assertive in determining the way aid from a foreign country should be used in health fields. This is a most welcome trend. However, how did the Government develop the 'model' for using the foreign aid? What have been the inputs from operational research in formulating the 'model' for Area Health Programmes in India? Indeed the area Health Programmes can be called the very embodiment of the "more of the same approach" which is so severely decried in the statement on national health policy.

Past Initiatives

It may be pointed out that way back in 1943-46, the Bhore Committee had taken policy initiatives which were even bolder than those taken in the statement on the national health policy; no individual should fail to secure adequate medical care because of inability to pay for it; from the very beginning health programme must lay special emphasis on preventive work; the debt which India owes to the tiller of the soil is immense and although he pays the heaviest toll when famine and pestilence sweep through the land, the medical attention he receives is of the most meagre description. The need is urgent for providing as much medical relief and preventive health care as possible to this group; health services should be placed as close to the people as possible; it is essential to secure the active cooperation of the people in the development of health programmes; the need for the fullest co-operation between health personnel and the people whom they serve is essential; the physician of tomorrow will be a social physician who will protect the people and guide them to a healthier and happier life, health services should be totally integrated, with the specialist health administrators occupying the key positions; finally, health promotion requires an intersectoral approach.

Indeed, even earlier (1940), the National Health Sub-committee of the National Planning Committee of the Indian National Congress had gone a step further to recommend large scale training of workers chosen from villages to entrust "people's health in people's hands".

What forces led these committees to take much bold policy initiatives? Why should the existing conditions be so dismal, despite the policy initiatives taken more than three and a half decades ago? What led to the adoption of fresh initiatives in the national health policy and why is it that along with laudable policy initiatives, the statement contains so many obviously simplistic assumptions about health services development in India?

What will be the future of the statement on the national health policy? Will it be followed by a more comprehensive policy statement

health services development in India or will it meet same fate as the reports of the Bhore Committee and the National Planning Committee?

Answers to such questions are important for drawing up a strategy for the future for providing "Health for all by 2000 AD". However, scholars have not paid adequate attention to such questions. Probably, both the Bhore Committee and the National Planning Committee came into being at a particularly fortuitous period in the history of the country; the nationalist movement was reaching its climax; there was a crisis in the western world in the form of the World War II; and both the Committees had a particularly dedicated and imaginative band of public health specialists, administrators, political leaders and social reformers.

The setting for the present statement on health policy is entirely different. Besides, the authors of the statement also had the experience of the two Committees available to them.

Probably it is the forces of democratisation which have impelled them to take the bold policy initiatives. As the statement is essentially a concession wrested by the people, it has gone only some way. Whether it meets the fate of the report of the other two committees or whether it would go the entire way will probably be determined by the rate of growth of democratisation in India in the coming years. In all likelihood, this time the pressure from the people will impel the leadership to go the entire way.

*Prof Debabar Banerji has had a background of medical service in the Himalayan region.

He is devoted to writing on social and community medicine. At present he is Director of the Centre of Social Science and Community Medicine, Jawaharlal Nehru University, New Delhi.

(This article was reprinted from the Economic and Political weekly of January 22, 1983 with permission from the author.)

Newly Qualified Medical Graduates and the National Health Policy

Dr S.N. Chaudhuri*

India as a nation has one of the largest output of medical graduates in the world.

Thousands of these young men and women, considered by many as the "cream of our society", educated and nurtured at a considerable cost to the nation, should be available to implement the different aspects of the Government's National Health Policy.

It is necessary to review, however, critically the end products of the existing medical education system i.e. the doctors, and explore ways of utilising this "precious" resource.

Many do not consider this resource of "qualified" medical graduates precious at all in view of the increasing suffering which has been inflicted on our less-fortunate brothers and sisters overburdened with poverty, malnutrition, illiteracy, social injustice etc.

Let us now place ourselves in the position of a young intern who is about to qualify as a doctor. The following points are a summary of discussions and interviews held with newly qualified medical graduates from different institutions all over the country.

The Problems

1. Mounting unemployment.
2. Ideological clash. Performance of the student's role model.
3. Limited job opportunities in innovative programmes.
4. Inadequate counselling services. Little opportunity for organised exposure to successful programmes around India

How do doctors end up?

1. Continue to work as house surgeons or physicians. Go on as registrars for a few years in a speciality.
2. Undertake post-graduate studies. Lucky few get into surgery, medicine, pediatrics, obstetrics, etc.
3. Economic pressures lead to:
 - 3.1 Salaried job with the State Health Services, public undertakings or private agencies.
 - 3.2 General practice.

Go abroad. Exodus to the West, later to the oil rich countries.

2. National Health Policy (NHP) states?

Need for Medical and health education.

- 1.1 Restructuring of curriculum possible with the help of Medical Council of India and concerned universities.
- 1.2 Quality of trainers. All faculty members belonging to different specialities should be committed to the NHP, particularly those belonging to Departments of Preventive and Social Medicine.
- 1.3 Proper exposure of students and interns to field practice areas attached to medical colleges.

2. Quality of training to "front line workers" can be effectively given by doctors, nurses, senior paramedical staff and those from other disciplines.

sted corrective measures

1. Set up formal/informal counselling services at all medical colleges/universities.
2. Organise debates, lectures, group discussions on the relevance of primary health care, specially to attract students during the early impressionable years.
3. Provide opportunities to visit innovative community health projects through organised tours for students, first on a regional and subsequently at national level.
4. Arrange placement of medical students for short periods and subsequently for longer periods and on graduation in successful projects.
5. Provide opportunities through guidance and procurement of funds, to entrepreneur or "innovators", willing to initiate primary health care projects in remote areas of the country.

Most of the corrective measures suggested above are being experimented with in a very limited way at the Child In Need Institute, West Bengal.

Some of the difficulties faced in implementing the proposal are the lack of transport to organise group-tours for medical students, insufficient commitment to this concept by heads of clinical departments etc. Despite these constraints, there is a tremendous potential of being able to organise the end-products of the medical education system prevalent in the country.

*Dr Samir Chaudhuri - his total commitment to Integrated Child Development Services led him to establish the Child in Need Institute(CINI) in West Bengal.

His revolutionary fervour is transparent and infectious. His services were found invaluable during the war crisis in Kampuchea when he was called upon to help in medical relief to refugees.

A paediatrician by training, he is now keen to develop a special internship programme for doctors, which will bring them in touch with the real needs in the primary health care sector and inspire them to accept rural services.

He is the Director of CINI in Daulatpur Village, P.O. Amgachi, 24 Parganas, West Bengal.

Medical and Health Education has to be Need-Based

Dr W.V. Rane*

You have selected a topic that reads as "Medical education towards low cost drugs and rational therapeutics". I feel the order should be reversed and it should be read as rational therapeutics and then low cost drugs. Because rational therapeutics would eliminate most of the unwanted drugging and would lead to minimal but essential drugging. The essential drugs are easily available at sufficiently low cost.

Medical and health education has to be need-based.

Our doctors are grossly ignorant of our food values and readily turn to synthetic foods.

Particularly in developing countries newer drugs are dumped, whereas their draw-backs are never disclosed.

The knowledge of practising doctors regarding the drugs in the market are also very poor.

This can be partly corrected by imparting continuing information on newer and old drugs in use, and modern trends in treatment of certain diseases. This should be done by an impartial agency.

We at Arogya Dakshata Mandal, Pune have been doing this for the last three years. We publish:

1. Pune Journal of Continuing Health Education, a monthly journal published in English, for the medical profession.
2. Arogya Vignyan, a marathi monthly giving basic information on diseases and it's early home treatment. It highlights nutritional, preventive, curative and social aspects of medical treatment. It reaches the educated common man.
3. Silver Oak, a Marathi pictorial monthly for the neo-literates to educate them on health matters.

Very often it is said that medical conferences and medical seminars and the referresher courses are not very enthusiastically attended by doctors. It is so, because they feel that their needs are not satisfied.

Our experience is very encouraging. Many doctors really want to know the other side of the coin-they have only to be made aware of it. They are very much interested to know the rational and practical therapeutics. Unfortunately they don't know how and where to get it. Here in would come as organisation like the Voluntary Health Association of India or any other all India organisation that can undertake this work. We are always willing to cooperate with any such organisation.

As long as the institution of quacks continues and as long as it really gives the much needed medical help in remote interiors, it should be our duty to keep them informed. We may even go a step further and try to give this knowledge and information in important regional languages.

*Dr Rane is involved in significant work in educating medical and other health personnel regarding drugs and their uses.

He is co-editor of the Pune Journal of Continuing Education.

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Belated Acknowledgement

Dr Usha Bannerji, Co-ordinator, National Students Service, Delhi University and Ms Gopa Lal of the Institute of Haematology have been missed in our page thanking all those associated with the seminar.

Dr Bannerji and Ms Lal did an admirable job at the Registration and Exhibition counters.

Eradication of Leprosy from India

*Prahlad Das**

from compassion and care for the ostracised leprosy afflicted, to employment of technological control in the Nehru era, the country has emerged into the horizon of eradication of the disease.

Mr M.S. Swaminathan's recommendations have been adopted by the Government and an effort has been made on a war-footing in this regard. The following ingredients are the essentials of the movement:

- i) In leprosy work, conviction must be of the heart. If it is of the head, then the programme may not achieve the desired success.
- ii) It is essential to combine the medical, the social and the human aspects of the problem and view all of them in their totality.

It was the religious, moral and social dedication that had sustained the movement over the ages all over the world. The stigma has however persisted inspite of the scientific discoveries that ushered an age of conviction that the disease was not a curse, not combatable like some other human ailments.

But the movement failed to draw dedicated medicos and social workers in its fold. The attempt was confined to a few pockets in Southern India, by voluntary organisations, who held the field and inspired the nation. Leprosy is item 14 in the Prime Minister's Twenty Point Programme.

The National Health Policy further lays down that "a Cure Programme be initiated immediately on a pilot scale in a few selected areas." These are words of wisdom and from past experience. We must establish model units in the public sector to create confidence in the masses, and demonstrate that the heart and the head combines with modern medical science, along with the willing cooperation of the leprosy patients to produce a cure. Sustained care, patience and mutual dedication are the basis of a breakthrough.

Established leprosy organisations all over the country today suffer from diverse pressures. If the Government participates actively, these units may be brought up to the expected standard of service.

*Prahlad Das is a veteran in the field of leprosy eradication. His total commitment to the national programme of leprosy eradication is commendable. Shri Das may be contacted C/o Kashi Kushta Seva Sangh, Sarnath, Varanasi - 221001, Uttar Pradesh.

Questionnaires

Questionnaires on the five subjects selected for discussions at the seminar on National Health Policy were circulated amongst the participants before the seminar opened.

HEALTH CARE EDUCATION AND TRAINING

The following questions were asked of those participating in the group discussing Health Care Education and Training:

1. What cadres of health workers do you consider crucial for effective work at the village level, the Primary Health Centre, the District Hospital level?
2. What should be the selection criteria for health personnel for medical education?
3. What specific inputs would you consider crucial in training and making of a socially conscious health functionary?
4. What drastic changes in the contents and the teaching methods would you recommend?
5. Who should be involved in the drawing up of the curriculum for alternative medical education and training?
6. What other disciplines, which are indirectly but crucially related to health, should be included in this education and training?
7. What should be the criteria for evaluating and assessment of knowledge, skills and attitudes of health care workers?
8. How do you think a system of ongoing education and training could be worked out?
9. What is the role of doctors with integrated medical training (i.e. Bachelor of Ayurvedic Medical Sciences or BAMS)?
10. What is the role of rural medical partitioners? How can the registration of Rural Medical Practitioner's Associations be adequately monitored and checked?
11. Whom should the health personnel be accountable to?

NUTRITION

The following questions were asked of participants discussing Nutrition:

1. a) What should be the nutrition content, quality and quantitywise, of the primary health care services delivered to the people in peripheral areas?
b) Is the present system satisfactory? If not, what are its weaknesses and how to overcome them?
2. Can nutrition services be delivered by non-health agencies? If so by whom and for whom?
3. What are the simple indicators to evaluate nutritional status within the primary health care system? What criteria should these indicators satisfy?
4. What are the major nutritional problems of the vulnerable segments?
5. What nutrition programmes are in operation for the different vulnerable segments of the population? What are their drawbacks and how can these be corrected?
6. Your views on Feeding Programmes. Are they useful?
7. What are the major food toxins and how can they be removed?
8. What socio-cultural practices, related to health, are in existence in your area? What impact do they have on the nutrition status of the population?
9. How can the nutrition status be improved with so many constraints?

ENVIRONMENT

The following questions were asked of participants meeting on Environment:

1. Why is an important basic health need like water being dealt with by the Housing and not the Health Department?
2. How effectively have the health authorities dealt with the increasing discharge of toxic effluents into the rivers, the only available drinking water sources for many?
3. What monitoring mechanism has been set up for water and air pollution and what action has been taken against those guilty on these counts?
4. With Water being a priority and - this being the Decade for Providing Potable Water to All - what facilities are available to the voluntary organizations in this regard?

5. What Government facilities are being offered for setting up smokeless chulahs, ELP slabs and bathing huts for women? How does a voluntary group or individual go about obtaining these facilities from the Government? Are you aware of the work of the Safai Vidyalaya, Ahmedabad, and the Sulabh Shauchalaya, Patna?
6. Do health authorities see any role in suggesting the kind of species of trees to be planted under the social forestry schemes instead of only Eucalyptus? If so, what? And how are they made available?
7. Why is occupational health being dealt with by the Labour Department?
8. Do the health authorities feel they have anything to say about the increase in the number of state licensed and state owned liquor shops, specially in the poverty stricken tribal area? Is state revenue more important than the health of the people?
9. Do health authorities seriously feel that non-availability of adequate and standard quality ration from ration shops is a health problem? If so, why are the complaints of consumers not taken seriously? Food inspectors are known to be purchasable. Is there any vigilance on this account in your region?
10. Regarding use of dangerous pesticides and their containers, what role have health authorities played in educating people about these dangers and their proper use? How do doctors receive information about the different brands available and the clinical picture of their early and late toxicity? We would like to have all the official information being given at different levels.
11. Is it to be presumed that all pesticides in the market have clearance from our health authorities?
12. What role would you want the voluntary organizations to play in dealing with the environmental health problems?
13. What has been the extent of poisoning and crippling due to adulteration of mustard oil?
14. What is the extent of endemic goitre and what is the volume of iodized salt production? Is it adequate? If not, why not?
15. What concrete steps have been taken to deal with the problem of guinea worms?

LOW COST DRUGS AND RATIONAL THERAPEUTICS

The following questions were asked of participants discussing Low Cost Drugs And Rational Therapeutics:

1. Are there any shortages of essential and life saving drugs in your area?
2. If there are any serious side effects due to drugs, how and to whom are they reported and what is the follow up?
3. Are the doctors and chemists adequately informed about the drugs being banned and how?
4. Are you aware of the concept of the essential drug list as recommended by WHO and the Hathi Commission? If so, what are your views on the subject?
5. What information can you give about the availability of drugs in the Government health centres and institutions in your area. Are they available in adequate quantities and are they of standard quality? What can and should be done?
6. In what role do you visualise the Government, a national coordinating health agency like VHAI, the individual health personnel, the consumers, and yourself in this issue of drugs? (The aim of these questions being to ensure that only essential drugs are available and utilized when needed and financial resources of the people are not wasted on irrational and hazardous drugs)

POPULATION STABILIZATION

The following questions were asked of the participants discussing Population Stabilization:

1. What are the maternal mortality and infant mortality figures in your area?
2. How effective is the MCH Programme in your area? What are the lacunae that need to be filled in this field and how?
3. What role do you see the voluntary organizations playing in the MCH and in family planning programmes?
4. What contraceptives are easily available and promoted in your area?
5. Do you feel that the increasing population is a major cause of the poverty and the poor health of our people?
6. What is the attitude of the people towards family planning workers? How could this work be made more humane?

7. Do you feel adequately informed about the different control methods, the problems associated with them and contraceptives their advantages, and results of their use in the field?
8. Are you aware of any indigenous methods of family spacing and birth control which you would like to share with others?
9. Do you feel birth control is primarily the women's responsibility or that men should equally shoulder this responsibility?
10. Do you feel that some of the available contraceptive devices may be hazardous to women's health and should not be propagated?

What are they?

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APPENDICES

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STATEMENT ON NATIONAL HEALTH POLICY

GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
NEW DELHI

1982

Introductory

1. The Constitution of India envisages the establishment of a new social order based on equality, freedom justice and the dignity of the individual. It aims at the elimination of poverty, ignorance and illhealth and directs the State to regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties, securing the health and strength of worker men and women, specially ensuring that children are given opportunities and facilities to development in healthy manner.
- 1.2 Since the inception of the planning process in the country, the successive Five-Year Plans have been providing the frame work within which the States may develop their health services infrastructure, facilities for medical education, research etc. Similar guidance has sought to be provided through the discussions and conclusions arrived at in the Joint Conference of the Central Councils of Health and Family Welfare and the National Development Council. Besides, Central legislation has been enacted to regulate standards of medical education, prevention of food adulteration, maintenance of standards in the manufacture and sale of certified drugs, etc.
- 1.3 While the broad approaches contained in the successive Plan documents and discussions in the forums referred to in para 1.2 may have generally served the needs of the situation in the past, it is felt that an integrated, comprehensive approach towards the future development of medical education research and health services requires to be established to serve the actual health needs and priorities of the country. It is in this context that the need has been felt to evolve a National Health Policy.

Our heritage

2. India has a rich, centuries-old heritage of medical and health sciences. The philosophy of Ayurveda and the surgical

skills enunciated by Charaka and Shusharuta bear testimony to our ancient tradition in the scientific health care of our people. The approach of our ancient medical systems was of a holistic nature, which took into account all aspects of human health and disease. Over the centuries, with the intrusion of foreign influences and mingling of cultures, various systems of medicine has, in a relatively short period of time, made a major impact on the entire approach to health care and pattern of development of the health services infrastructure in the country.

gress achieved

3. During the last three decades and more, since the attainment of Independence, considerable progress has been achieved in the promotion of the health status of our people. Smallpox has been eliminated; plague is no longer a problem; mortality from cholera and related diseases has decreased and malaria brought under control to a considerable extent. The mortality rate per thousand of population has been reduced from 27.4 to 14.8 and the life expectancy at birth has increased from 32.7 to over 52. A fairly extensive network of dispensaries, hospitals and institutions providing specialized curative care has developed and a large stock of medical and health personnel of various levels, has become available. Significant indigenous capacity has been established for the production of drugs and pharmaceuticals, vaccines, sera, hospital equipments, etc.

e existing picture

4. In spite of such impressive progress, the demographic and health picture of the country still constitutes a cause for serious and urgent concern. The high rate of population growth continues to have an adverse effect on the health of our people and the quality of their lives. The mortality rates for women and children are still distressingly high; almost one third of the total deaths occur among children below the age of 5 years; infant mortality is around 129 per thousand live births. Efforts at raising the nutritional levels of our people have still to bear fruit and the extent and severity of malnutrition continues to be exceptionally high. Communicable and non-communicable diseases have still to be brought under effective control and eradicated. Blindness, Leprosy and T.B. continue to have a high incidence. Only 31% of the rural population has access to potable water supply and 0.5% enjoys basic sanitation.

- 4.1 High incidence of diarrhoeal diseases and other preventive and infectious diseases, specially amongst infants and children, lack of safe drinking water and poor environmental sanitation, poverty and ignorance are among the major contributory causes of the high incidence of disease and mortality.

- 4.2 The existing situation has been largely engendered by the almost wholesale adoption of health manpower development

policies and the establishment of curative centre based on the Western models, which are inappropriate and irrelevant to the real needs of our people and the socio-economic conditions obtaining in the country. The hospital-based disease, and cure-oriented approach towards the establishment of medical services has provided benefits to the upper crusts of society, specially those residing in the urban areas. The proliferation of this approach has been at the cost of providing comprehensive primary health care services to the entire population, whether residing in the urban or the rural areas. Furthermore, the continued high emphasis on the curative approach has led to the neglect of the preventive, promotive, public health and rehabilitative aspects of the health care. The existing approach instead of improving awareness and building up self-reliance, has tended to enhance dependency and weaken the community's capacity to cope with its problems. The prevailing policies in regard to the education and training of medical and health personnel, at various levels, has resulted in the development of a cultural gap between the people and the personnel providing care. The various health programmes have, by and large, failed to involve the individuals and families in establishing a self-reliant community. Also, over the years, the planning process has become largely oblivious of the fact that the ultimate goal of achieving a satisfactory health status for all our people cannot be secured without involving the community in the identification of their health needs and priorities as well as in the implementation and management of the various health and related programmes.

*Need for evolving a health policy
based on the revised 20-point programme*

5. India is committed to attaining the goal of "Health for all by the year 2000 A.D." through the universal provision of comprehensive primary health care services. The attainment of this goal requires a thorough overhaul of the existing approaches to the education and training of medical and health personnel and the reorganisation of the health services infrastructure. Furthermore, considering the large variety of inputs into health, it is necessary to secure the complete integration of all plans for health and human development with the overall national socio-economic development process, and specially in the more closely health related sectors, e.g. drugs and pharmaceuticals, agriculture and food production, rural development, education and social welfare, housing, water supply and sanitation, prevention of food adulteration, maintenance of prescribed standards in the manufacture and sale of drugs and the conservation of the environment. In sum, the contours of the National health Policy have to be evolved within a fully integrated planning framework which seeks to provide universal comprehensive primary health care services, relevant to the actual needs and priorities of the community at a cost which the people can afford, ensuring that the planning and implementation of the various health programmes is through the organised involvement

and participation of the community, adequately utilising the services being rendered by private voluntary organisations active in the health sector.

- 5.1 It is also necessary to ensure that the pattern of development of the health services infrastructure in the future fully takes into account the revised 20-point programme. The said programme attributes very high priority to the promotion of family planning as a people's programme, on a voluntary basis, substantial augmentation and provision of primary health facilities on a universal basis; control of leprosy, T.B. and Blindness; acceleration of welfare programmes for women and children; nutrition programmes for pregnant women, nursing mothers and children, especially in the tribal, hill and backward areas. The programme also places high emphasis on the supply of drinking water to all problem villages, improvements in the housing and environments of the weaker section of society; increased production of essential food items; integrated rural developments; spread of universal elementary education, expansion of the public distribution systems, etc.

population stabilisation

6. Irrespective of the changes, no matter how fundamental, that may be brought about in the over-all approach to health care and the restructuring of the health services, not much headway is likely to be achieved in improving the health status of the people unless success is achieved in securing the small family norm, through voluntary efforts, and moving towards the goal of population stabilisation. In view of the vital importance of securing the balanced growth of the population it is necessary to enunciate, separately, a National Population Policy.

medical and health education

7. It is also necessary to appreciate that the effective delivery of health care services would depend very largely on the nature of education, training and appropriate orientation towards community health of all categories of medical and health personnel and their capacity to function as an integrated team, each of its members performing given tasks within a coordinated action programme. It is therefore, of crucial importance that the entire basis and approach towards medical and health education, at all levels, is reviewed in terms of national needs and priorities and the curricular and training programmes restructured to produce personnel of various grades of skill and competence, who are professionally equipped and socially motivated to effectively deal with day-to-day problems, within the existing constraints. Towards this end, it is necessary to formulate, separately, a national medical and health education Policy which (i) sets out the changes required to be brought about in the curricular contents and training programme of medical and health personnel, at various levels of functioning; (ii) takes into account the need for establishing the extremely essential inter-relations between functionaries of various grades (iii) provides guidelines for the production of health

personnel on the basis of realistically assessed manpower requirements; (iv) seeks to resolve the existing sharp regional imbalances in their availability; and (v) ensures that personnel at all levels are socially motivated towards the rendering of community health services.

Need for providing primary health care with special emphasis on the preventive, promotive and rehabilitative aspects:

8. Presently, despite the constraint of resources, there is disproportionate emphasis on the establishment of curative centres-dispensaries, hospitals, institutions for specialist treatment - the large majority of which are located in the urban areas of the country.

The vast majority of those seeking medical relief have to travel long distances to the nearest curative centre, seeking relief for ailments which could have been readily and effectively handled at the community level. Also for want of a well established referral system, those seeking curative care have the tendency to visit various specialist centres, thus further contributing to congestions, duplication of efforts and consequential waste of resources. To put an end to the existing all-round unsatisfactory situation, it is urgently necessary to restructure the health services within the following broad approach:

- (1) To provide within a phased, time-bound programme a well dispersed network of comprehensive primary health care services, integrally linked with the extension and health education approach which takes into account the fact that a large majority of health functions can be effectively handled and resolved by the people themselves with the organised support of volunteers, auxiliaries, para-medicals and adequately trained multi-purpose workers of various grades of skill and competence, of both sexes. There are a large number of private, voluntary organisations active in the health field all over the country. Their services and support would require to be utilised and intermeshed with the governmental efforts, in an integrated manner.
- (2) To be effective, the establishment of the primary health care approach would involve large scale transfer of knowledge, simple skills and technologies to health volunteers, selected by the communities and enjoying their confidence. The functioning of the front line of workers, selected by the community would require to be related to definitive action plans for the translation of medical and health knowledge into practical action, involving the use of simple and inexpensive intervention which can be readily implemented by persons who have undergone short periods of training. The quality of training of these health guides/workers would be of crucial importance to the success of this approach.

- (3) The success of the decentralised primary health care system would depend vitally on the organised building up of individual self-reliance and effective community participation; on the provision of organised, back-up support of the secondary and tertiary levels of the health care services, providing adequate logistical and technical assistance.
- (4) The decentralisation of services would require the establishment of a well worked out referral system to provide adequate expertise at the various levels to the organisational set-up nearest to the community, depending upon the actual needs and problems of the area, and thus ensure against the continuation of the existing rush towards the curative centres in the urban areas. The effective establishment of the referral system would also ensure the optimal utilisation of expertise at the higher levels of the hierarchical structure. This approach would not only lead to the progressive improvement of comprehensive health care services at the primary level but also provide for timely attention being available to those in need of urgent specialist care, whether they live in the rural or the urban areas.
- (5) To ensure that the approach to health care, does not merely constitute a collection of disparate health interventions but consists of an integrated package of services seeking to tackle the entire range of poor health conditions, on a broad front, it is necessary to establish a nation-wide chain of sanitary-cum-epidemiological stations. The location and functioning of these stations may be between the primary and secondary levels of the hierarchical structure, depending upon the local situations and other relevant considerations. Each such station would require to have suitable trained staff equipped to identify, plan and provide preventive, promotive and mental health care services. It would be beneficial, depending upon the local situations, to establish such stations at the Primary Health Centres. The district health organisation should have, as an integral part of its set-up, a well organised epidemiological unit to coordinate and superintend the functioning of the field stations. These stations would participate in the integrated action plans to eradicate and control diseases, besides tackling specific local environmental health problems. In the urban agglomerations, the municipal and local authorities should be equipped to perform similar functions, being supported with adequate resources and expertise, to effectively deal with the local preventable public health problems. The aforesaid approach should be implemented and extended through community participation and contributions, in whatever form possible, to achieve meaningful results within a time-bound programme.
- (6) The location of curative centres should be related to the populations they serve keeping in view the densities

of population, distances, topography, transport connections. These centres should function within the recommended referral system, the gamut of the general specialities required to deal with the local disease patterns being provided as near to the community as possible, of the secondary level of the hierarchical organisation. The concept of domiciliary level and the field-camps approach should be utilised to the fullest extent, to reduce the pressures on these centres, specially in efforts relating to the control and eradication of Blindness, Tuberculosis, Leprosy, etc. To maximise the utilisation of available resources, new and additional curative centres should be established only in exceptional cases, the basic attempt being towards the upgradation of existing facilities, at selected locations, the guiding principle being to provide specialist services as near to the beneficiaries as may be possible, within a well-planned network. Expenditure should be reduced through the fullest possible use of cheap locally available building materials resort to appropriate architectural designs and engineering concepts and by economical investment in the purchase of machineries and equipments, ensuring against avoidable duplication of such acquisitions, it is also necessary to devise effective mechanisms for the repair, maintenance and proper upkeep of all bio-medical equipments to secure their maximum utilisation.

(7) With a view to reducing governmental expenditure and fully utilising untapped resources, planned programmes may be devised, related to the local requirements and potentials, to encourage the establishment of practice by private medical professional, increased investment by non-governmental agencies establishing curative centres and by offering organised logistical, financial and technical support to voluntary agencies active in health field.

(8) While the major focus of attention in restructuring the existing governmental health organisations would relate to establishing comprehensive primary health care and public health services, within an integrated referral system, planned attention would also require to be devoted to the establishment of centres equipped to provide speciality and super-speciality service, through a well dispersed net work of centres, to ensure that the present and future requirements of specialist treatment and adequately available within the country. To reduce governmental expenditures involved in the establishment of such centres, planned efforts should be made to encourage private investments in such fields so that the majority of such centres, within the governmental set up, can provide adequate care and treatment to those entitled to free care, the affluent sectors being looked after by paying clinics. Care would also require to be taken to ensure the appropriate dispersal of such centres, to remove the existing regional imbalances and

to provide services within the reach of all, whether rural or the urban areas.

- (9) Special, well coordinated programmes should be launched to provide mental health care as well as medical care and the physical and social rehabilitation of those who are mentally retarded, deaf, dumb, blind, physically disabled, infirm and the aged. Also, suitably organised programmes would require to be launched to ensure against the prevention of various disabilities.
- (10) In the establishment of the re-organised services, the first priority should be accorded to provide services to those residing in the tribal, hill and backward areas as well as to endemic disease affected populations and the vulnerable sections of the society.
- (11) In the re-organised health services scheme, efforts should be made to ensure adequate mobility of personnel all levels of functioning.
- (12) In the various approaches, set out in (1) to (11) above organised efforts would require to be made to fully utilise and assist in the enlargement of the services being provided by private voluntary organisations active in the health field. In this context, planning encouragement and support would also require to be afforded to fresh voluntary efforts, specially those which seek to serve the need of the rural areas and the urban slums.

Reorientation of the existing health personnel

9. A dynamic process of change and innovation is required to be brought in the entire approach to health manpower development, ensuring the emergence of fully integrated bands of workers functioning within the "Health Team" approach.

Private practice by governmental functionaries

10. It is desirable for the States to take steps to phase out the system of private practice by medical personnel in government service, providing at the same time for payment of appropriate compensatory nonexisting allowance. The State would require to carefully review the existing situation, with special reference to the availability and dispersal of private practitioners, and take timely decisions in regard to this vital issue.

Practitioners of indigenous and other systems of medicine and their role in health care

11. The country has a large stock of health manpower comprising of private practitioners in various systems, for example, Ayurvedic, Unani, Sidha, Homoeopathy, Yoga, Naturopathy etc.

This resource has not so far been adequately utilised. The practitioners of these various systems enjoy high local acceptance and respect and consequently exert considerable influence on health beliefs and practices. It is, therefore, necessary to initiate organised measures to enable each of these various systems of medicine and health care to develop in accordance with its genius. Simultaneously, planned effort should be made to dovetail the functioning of the practitioners of these various systems and integrate their services, at the appropriate levels, within specified areas of responsibility and functioning, in the over-all health care delivery system, specially in regard to the preventive, promotive and public health objectives. Well considered steps would also require to be launched to move towards a meaningful phased integration of the indigenous and the modern systems.

*Problems requiring
urgent attention*

12. Besides the recommended restructuring of the health services infrastructure, reorientation of the medical and health manpower, community involvement and exploitation of the services of private medical practitioners, specially those of the traditional and other systems, involvement and utilisation of the services of the voluntary agencies active in the health field, etc., it would be necessary to devote planned, time-bound attention to some of the more important inputs required for improved health care. Of these, priority attention would require to be devoted to:

- (i) Nutrition: National and regional strategies should be evolved and implemented, on a time-bound basis, to ensure adequate nutrition for all segments of the population through a well developed distribution system, specially in the rural areas and urban slums. Food of acceptable quality must be available to every person in accordance with his physical needs. Low cost, processed and ready-to-eat food should be produced and made readily available. The over-all strategy would necessarily involve organised efforts of improving the purchasing power of the poorer sections of the society. Schemes like employment guarantee scheme, to which the government is committed could yield optimal results if these are suitably linked to the objective of providing adequate nutrition and health cover to the rural and the urban poor. The achievement of this objective is dependent on integrated socio-economic development leading to the generation of productive employment for all those constituting the labour force. Employment guarantee scheme and similar efforts would require to be specially enforced to provide social security for identified vulnerable sections of the society. Measures aimed at improving eating habits, inculcation of desirable nutritional practices, improved and scientific utilisation of available food materials and the effective popularisation of improved cooking practices would require to be implemented. Besides, a nation-wide programme to promote

breast feeding of infants and eradication of various social taboos detrimental to the promotion of health would need to be initiated. Simultaneously, the problems of communities afflicted by chronic nutritional disorders should be tackled through special schemes including the organisation of supplementary feeding programmes directed to the vulnerable sections of the population. The force and effect of such programmes should be ensured by delivering them within the setting of fully integrated health care activities, to ensure the inculcation of the educational aspects, in the over-all strategy.

- (ii) Prevention of food adulteration and maintenance of the quality of drugs: Stringent measures are required to be taken to check and prevent the adulteration and contamination of foods at the various stages of their production, processing, storage, transport, distribution, etc. To ensure uniformity of approach, the existing law would require to be reviewed and effective legislation enacted by the Centre. Similarly the most urgent measures require to be taken to ensure against the manufacture and sale of spurious and substandard drugs.
- (iii) Water supply and sanitation : The provision of safe drinking water and the sanitary disposal of waters, human and animal wastes, both in urban and rural areas, must constitute an integrated package. The enormous backlog in the provision of these services to the rural population and in the urban agglomerations must be made up on the most urgent basis. The provision of water supply and basic sanitation facilities would not automatically improve health. The availability of such facilities should be accompanied by intensive health education campaigns for the improvement of personal hygiene, the economical use of water and the sanitary disposal of waste in a manner that will improve individual and community health. All water-supply schemes must be fully integrated with efforts at proper water management, including the drainage and disposal of waste waters. To reduce expenditures and for achieving a quick headway it would be necessary to devise appropriate technologies in the planning and management of the delivery systems. Besides, the involvement of the community in the implementation and management of the systems would be of crucial importance both for reducing costs as well as to see that the beneficiaries value and protect the services provided to them.
- (iv) Environmental protection : While preventive, promotive, public health services are established and the curative services re-organised to prevent, control and treat diseases, it would be equally necessary to ensure against the haphazard exploitation of resources which

cause ecological disturbances leading to fresh health hazards. It is, therefore, necessary that economic development plans, in the various sectors, are devised in adequate consultation with the Central and the State Health authorities. It is also vitally essential to ensure that the present and future industrial and urban development plans are centrally reviewed to ensure against congestions, the unchecked release of noxious emissions and the pollution of air and water. In this context, it is vital to ensure that the siting and location of all manufacturing units is strictly regulated through legal measures, if necessary. Central and State Health authorities must necessarily be consulted in establishing locational policies for industrial development and urbanisation programmes. Environmental appraisal procedures must be developed and strictly applied in according clearance to the various developmental projects.

- (v) Immunisation programme : It is necessary to launch an organised, nationwide immunisation programme, aimed at cent percent coverage of targetted population groups with vaccines against preventable and communicable diseases. Such an approach would not only prevent and reduce disease and disability but also bring down the existing high infant and child mortality rate.
- (vi) Maternal and child health service : A vicious relationship exists between high birth rates and high infant mortality, contributing to the desire for more children. The highest priority would, therefore, require to be devoted to efforts to launching special programmes for the improvement of maternal and child health, with a special focus on the less privileged sections of society. Such programmes would require to be decentralised to the maximum possible extent, their delivery being at the primary level, nearest to the doorsteps of the beneficiaries. While efforts should continue at providing refresher training and orientation to the traditional birth attendants schemes and programmes should be launched to ensure that progressively all deliveries are conducted by competently trained persons so that complicated cases receive timely and expert attention, within a comprehensive programme providing ante-natal, intra-natal and postnatal care.
- (vii) School health programme: Organised school health services, integrally linked with the general, preventive and curative services, would require to be established within time-limited programmes.
- (viii) Occupational health service : There is urgent need for launching well-considered schemes to prevent and treat diseases and injuries from occupational hazards, not only in the various industries but also in the comparatively un-organised sectors like agriculture. For this purpose, the coverage of the Employees State Insurance Act, 1948, may be suitably extended ensuring adequate coordination of efforts with the general health services. In their respective spheres of responsibility the Centre and the States must introduce organised

occupational health services to reduce morbidity, disabilities and mortality and thus promote better health and increased welfare and productivity on all fronts.

Health education

13. The recommended efforts, on various fronts, would bear only marginal results unless nation-wide health education programmes, backed by appropriate communication strategies are launched to provide health information in easily understandable form, to motivate the development of an attitude for healthy living. The public health education programme should be supplemented by health, nutrition and population education programmes in all educational institutions at various levels. Simultaneously, efforts would require to be made to promote universal education, specially adult and family education, without which the various efforts to organise preventive and promotive health activities, family planning and improved maternal and child health cannot bear fruit.

Management information system

14. Appropriate decision making and programme planning in the health and related fields is not possible without establishing an effective health information system. A nation-wide organisational set-up should be established to procure essential health information. Such information is required not only for assisting in planning and decision making but to also provide timely warnings about emerging health problems and for reviewing, monitoring and evaluating the various on-going health programmes. The building up of a well conceived health information system is also necessary for assessing medical and health manpower requirements and taking timely decisions, on a continuing basis, regarding the manpower requirement in the future.

Medical industry

15. The country has built up sound technological and manufacturing capability in the field of drugs, vaccines, bio-medical equipments, etc. The available know-how requires to be adequately exploited to increase the production of essential and life saving drugs and vaccines of proven quality to fully meet the national requirement, specially in regard to the national programmes to combat Malaria, TB, Leprosy, Blindness, Diarrhoeal diseases, etc. The production of the essential, life saving drugs under their generic names and the adoption of economical packaging practices would considerably reduce the unit cost of medicines bringing them within the reach of the poorer sections of society, besides significantly reducing the expenditure being incurred by the governmental organisation on the purchase of drugs. In view of the low cost of indigenous and herbal medicines, organised efforts may be launched to establish herbal gardens, producing drugs of certified quality and making them easily available.

- 15.1 The practitioners of the modern medical system rely heavily on diagnostic aids involving extensive use of costly, sophisticated biomedical equipment. Effective mechanisms should be established to identify essential equipments required for extensive use and to promote and enlarge their indigenous manufacture, for such devices being readily available, at reasonable prices, for use of the health care centres.

Health Insurance

16. Besides mobilising the community resources, through its active participation in the implementation and management of national health and related programmes, it would be necessary to devise well considered health insurance schemes, on a State-wise basis, for mobilising additional resources for health promotion and ensuring that the community shares the cost of the services, in keeping with its paying capacity.

Health legislation

17. It is necessary to urgently review all existing legislation and work towards a unified, comprehensive legislation in the health field, enforceable all over the country.

Medical research

18. The frontiers of the medical sciences are expanding at a phenomenal pace. To maintain the country's lead in this field as well as to ensure self-sufficiency and generation of the requisite competence in the future, it is necessary to have an organised programme for the building up and extension of fundamental and basic research in the field of bio-medical and allied sciences. Priority attention would require to be devoted to the resolution of problems relating to the containment and eradication of the existing, widely prevalent diseases as well as to deal with emerging health problems. The basic objective of medical research and the ultimate test of its utility would involve the translation of available know-how into simple, low-cost, easily applicable appropriate technologies, devices and interventions suiting local conditions, thus placing the latest technological achievements, within the reach of health personnel, and to the front line health workers, in the remotest corners of the country. Therefore, besides devotion to basic, fundamental research, high priority should be accorded to applied, operational research including action research for continuously improving the cost effective delivery of health services. Priorities would require to be identified and laid down in collaboration with social scientists, planners and decision makers and the public. Basic research efforts should devote high priority to the discovery and development of more effective treatment and preventive procedures in regard to communicable and tropical diseases - Blindness, Leprosy, T.B., etc. Very high priority would also have to be devoted to contraception research, to urgently improve the effectiveness of existing methods as well as discover more effective and acceptable devices. Equally high attention would

should be established to identify essential equipments required for extensive use and to promote and enlarge their resources to be devoted to nutrition research, to improve the health status of the community. The overall effort should aim at the balanced development of basic, clinical problem-oriented operational research.

Inter-sectoral cooperation

19. All health and human development must ultimately constitute an integral component of the overall socio-economic developmental process in the country. It is thus of vital importance to ensure effective coordination between the health and its more intimately related sectors. It is, therefore, necessary to set up standing mechanisms, at the Centre and in the States, for securing inter-sectoral coordination of the various efforts in the fields of health and family planning, medical education and research, drugs and pharmaceuticals, agriculture and food, water supply and drainage, housing, education and social welfare and rural development. The coordination and review, committees to be set up, should review progress, resolve bottlenecks and bring about such shifts in the contents and priorities of programmes as may appear necessary to achieve the overall objectives. At the community level it would be desirable to devise arrangements for health and all other developmental activities being coordinated under an integrated programme of rural development.

Monitoring and review of progress

20. It would be of crucial importance to monitor and periodically review, the success of the efforts made and the results achieved. For this purpose, it is necessary to urgently identify the base line situation and to evolve a phased programme for the achievement of short and long term objectives in the various sectors of activity. Towards this end, the current level of achievement as well as the broad indicators for the achievement of certain basic health and family welfare goals are set out in the annexed tabular statement*. These goals, as well as other allied objectives, would require to be further worked upon and specific targets for achievement established by the Central and the State governments in regard to the various functioning.

Reprinted and circulated by the Voluntary Health Association of India as a discussion document.

*Not printed

20-POINT PROGRAMME

THE new 20-point programme commended to the nation by the Prime Minister Smt Indira Gandhi on January 14, 1982 is as follows :

1. Increase irrigation potential, develop and disseminate technologies and inputs for dry land agriculture.
2. Take special efforts to increase production of pulses and vegetable oil seeds.
3. Strengthen and expand coverage of Integrated Rural Development and National Rural Employment Programmes.
4. Implement agricultural land ceilings, distribute surplus land and complete compilation of land records by removing all administrative and legal obstacles.
5. Review and effectively enforce minimum wages for agricultural labour.
6. Rehabilitate bonded labour..
7. Accelerate programmes for the development of Scheduled Castes and Tribes.
8. Supply drinking water to all problem villages.
9. Allot house sites to rural families who are without them and expand programmes for construction assistance to them.
10. Improve the environment of slums, implement programme of house-building for economically weaker sections, and take measures to arrest unwarranted increase in land prices.
11. Maximise power generation, improve the functioning of electricity authorities and electrify all villages.
12. Pursue vigorously programmes of afforestation, special and farm forestry and the development of biogas and other alternative energy sources.
13. Promote family planning on a voluntary basis as a people's movement.
14. Substantially augment universal primary health care facilities, and control of leprosy, T.B., and blindness.
15. Accelerate programmes of welfare for women and children and nutrition programmes for pregnant women, nursing mothers and children, specially in tribal, hill and backward areas.
16. Spread universal elementary education for the age group 6-14 with special emphasis on girls, and simultaneously involve students and voluntary agencies in programmes for the removal of adult literacy.
17. Expand the public distribution system through more Fair Price Shops, including mobile shops in far-flung areas and shops to cater to industrial workers, students hostels, and make available to students text - books and exercise-books on a priority basis and to promote a strong consumer protection movement.
18. Liberalise investment procedures and streamline industrial policies to ensure timely completion of projects. Give handicrafts, handlooms, small and village industries all facilities to grow and to update their technology.

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19. Continue strict action against smugglers, hoarders and tax evaders and check black money.
20. Improve the working of the public enterprises by increasing efficiency, capacity utilisation and the generation of internal resources.

